

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and that it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**13135** **CERTIFICATE OF DEATH** **13123**

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Md.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			
c. LENGTH OF STAY IN b. <b>3 weeks</b>				d. STREET ADDRESS <b>225 Maple St.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Western Maryland State Hospital</b>							
3. NAME OF DECEASED (Type or print) <b>DOMINIGO Domenico</b>				First <b>ALI</b>		Last	
5. SEX <b>Male</b>				6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
8. DATE OF BIRTH <b>July 26, 1890</b>				9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR: Months <b>11</b> Days <b>11</b> Year <b>1961</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Trackman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Caulonia, Italy</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Elarca Ali</b>			
14. MOTHER'S MAIDEN NAME <b>Catherine Lipari</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> War <b>I</b>			
16. SOCIAL SECURITY NO. <b>705-07-6706</b>				17. INFORMANT <b>Mrs. Marie Ali, Cumberland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GRANULOMA FUNGOIDES</b> <b>205X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>9 MONTHS</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from <b>10-20-</b> , 19 <b>61</b> , to <b>11-11-</b> , 19 <b>61</b> , that (I) (the hospital) last saw the deceased alive on <b>11-11-</b> , 19 <b>61</b> , and that death occurred at <b>11:55</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Antonios U. Pallacrosi</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>ANTONIO U. PALLACROSI</b>				22d. ADDRESS <b>1500 Pa. Ave. Hagerstown Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<b>Burial</b>		<b>Nov. 14, 1961</b>		<b>St. Ambrose Cemetery</b>		<b>Cresaptown, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR <b>NOV 14 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

13181

(M)

July 1, 1944

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C. H. H. H.

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July 1, 1944

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal. And in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
13136  
13124  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Williamsport RFD #2</b> d. STREET ADDRESS <b>Williamsport Md RFD #2</b>			
3. NAME OF DECEASED (Type or print) <b>Michael Todd Ausherman</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>11</b> Year <b>19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 10-61</b>		9. AGE (In years last birthday) <b>20</b>	IF UNDER 1 YEAR Months <b>20</b> Days <b>20</b> Hours <b>20</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Kenneth Ausherman</b>				14. MOTHER'S MAIDEN NAME <b>Sheridan Ann Cooper</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mr. Kenneth Ausherman</b> Address <b>Williamsport Md RFD #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congenital Atelectasis</b> 7620 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 10, 1961</b> , to <b>Nov. 11, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov. 11, 1961</b> , and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above. 22a. SIGNATURE <b>Philip J. Hirshman</b> 22b. DATE SIGNED <b>11/12/61</b> 22c. PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman</b> 22d. ADDRESS <b>Hagerstown Maryland</b> 22e. REC'D BY REGISTRAR <b>NOV 14 '61</b> 22f. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 13-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hagerstown Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Albert L. Stief</b> ADDRESS <b>Williamsport, Md</b> 25a. REC'D BY REGISTRAR <b>NOV 14 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

M

13118

Washington

Washington

Washington County Hospital

Alcohol

White

Woman

Married

born

Washington

Washington

Washington County Hospital

Alcohol

Nov. 10-11

Married

Married

born

Washington

Washington

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13137

## CERTIFICATE OF DEATH

13125

<b>1. PLACE OF DEATH</b> a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CLEAR SPRING</b> c. LENGTH OF STAY IN 1b <b>5 YRS.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>RESIDENCE</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CLEAR SPRING, MD.</b> d. STREET ADDRESS <b>S. MARTIN</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>BRONSON</b> First <b>BARNETT</b> Middle <b>BARNETT</b> Last		<b>4. DATE OF DEATH</b> <b>NOVEMBER 20 19 61</b> Month Day Year	
<b>5. SEX</b> <b>MALE</b> <b>WHITE</b> 6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>MAY 3, 1899</b> 9. AGE (In years last birthday) <b>62</b> yrs. <b>6</b> Months <b>17</b> Days <b>17</b> Hours <b>17</b> Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>PAINTER</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSE PAINTER</b> 11. BIRTHPLACE (County & State, or foreign country) <b>WOLF SUMMIT W. VA.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>EARL BARNETT</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>GENEVA JARVIS</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WORLD WAR 1</b>		<b>16. SOCIAL SECURITY NO.</b> <b>234-14-0207</b> <b>MILLARD E. SHANK</b> <b>CLEAR SPRING, MD.</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) <b>Acute Coronary Occlusion</b> <b>Sudden</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Healed Gastric Ulcer</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> <b>Clear Spring Md.</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Sept 15, 1961</b> <b>to</b> <b>Nov 20, 1961</b> <b>that (I) (we) last saw the deceased alive on</b> <b>Nov 17, 1961</b> <b>and that death occurred at</b> <b>11/24/61</b> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>David R. Brewer</b> M.D.		<b>22b. DATE SIGNED</b> <b>11/24/61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>David R. Brewer</b>		<b>22d. ADDRESS</b> <b>Clear Spring Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>11/22/61</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>BLOOMING ROSE CEMETERY</b>		<b>23d. LOCATION</b> (City, town or county) <b>FRIENDSVILLE, MD.</b> (State)	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Margaret R. Rowland</b>		<b>25a. REC'D BY REGISTRAR</b> <b>NOV 24 '61</b> DATE	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>			

2000

M

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13138

13126

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>23 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>209 High St.</u>				d. STREET ADDRESS <u>1 209 High St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Clyde</u> Middle <u>Hartle</u> Last <u>Barnhart</u>				4. DATE OF DEATH Month <u>November</u> Day <u>19</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 19, 1886</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Fairchild Aircraft</u>		11. BIRTHPLACE (County & State, or foreign country) <u>State Line, Penna.</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Harry W. Barnhart</u>				
14. MOTHER'S MAIDEN NAME <u>Ada Ann Hesser</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>				
16. SOCIAL SECURITY NO. <u>188-03-9951</u>			17. INFORMANT <u>Mrs. C. H. Barnhart</u> Address <u>209 High St. Hagerstown, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma - Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Heart Disease</u> (a), stating the underlying cause last. DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>240.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>June 26</u> , 19 <u>61</u> , to <u>Nov 19</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Sept 4</u> , 19 <u>61</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Philip J. Hirshman</u>			22b. DATE SIGNED <u>11/22/61</u>		22c. ADDRESS <u>159 W. Washington St. Hagerstown, Maryland</u>		
22c. PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D.</u>			22d. ADDRESS <u>159 W. Washington St. Hagerstown, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/22/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Host</u>			25a. REC'D BY REGISTRAR <u>Nov 21 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Christina S. Kraus</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11/13/50

11/13/50

(M)

(1)

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11/13/50

11/13/50

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

13139

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13127

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>5 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Hagerstown</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R # 6</u>		1d. STREET ADDRESS <u>R # 6</u>	
3. NAME OF DECEASED (Type or print) First <u>Edgar</u> Middle <u>Dale</u> Last <u>Barnhart</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>3</u> Year <u>19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 4, 1895</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u>    </u> Days <u>    </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maintenance</u>	
11. BIRTHPLACE (State or foreign country) <u>State Line, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry W. Barnhart</u>		14. MOTHER'S MAIDEN NAME <u>Ida Ann Hesser</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-14-6148</u>	
17. INFORMANT <u>Mrs. Edythe Moore</u>		Address <u>R # 6 Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>    </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Hypertension</u> DUE TO <u>Cerebral Hemorrhage</u> (c) <u>    </u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>    </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>    </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>    </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>    </u>		20f. (City or town) (County) (State) <u>    </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>A. Sw. Ditto</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/6/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel</u>		ADDRESS <u>Hagerstown, Md.</u>	
24a. REC'D BY REGISTRAR <u>    </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
DATE <u>NOV 7 '61</u>			

Wm. C. Hart



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

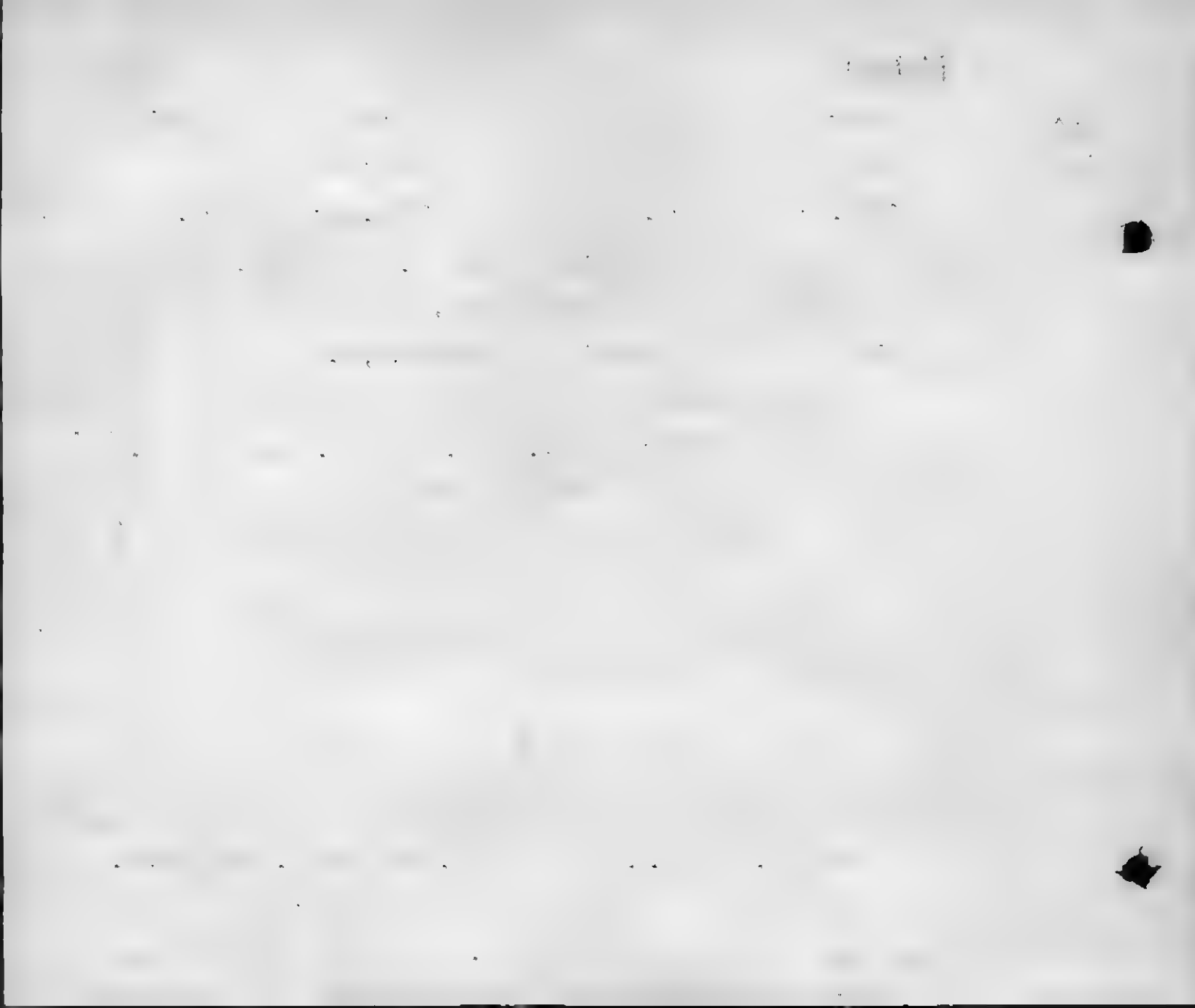
13140

13128

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Washington</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>300 S. Mount Valla Ave.</u>				e. STREET ADDRESS <u>300 S. Mount Valla Ave.</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Foster</u> Middle <u>Marcellus</u> Last <u>Batt Sr.</u>				<b>4. DATE OF DEATH</b> Month <u>Nov.</u> Day <u>2</u> Year <u>19 61</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 2, 1899</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Taxi driver</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Transportation</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Charles Edward Batt</u>			
14. MOTHER'S MAIDEN NAME <u>Sara Elizabeth Bowers</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>214-09-2236</u>				17. INFORMANT <u>Mrs. Lena J. Batt 300 S. Mount Valla Ave.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Hydrostatic Pneumonia</u> (b) <u>Hypertensive Cardiovascular Disease</u> (c) <u>Cerebral Spinal Lesion</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u> <u>6 yrs.</u> <u>30 yrs.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1, 1961</u> to <u>Nov 2, 1961</u> , that (I) (we) last saw the deceased alive on <u>Nov 2, 1961</u> , and that death occurred at <u>1:45</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert P. Conrad, M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-3-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert P. Conrad M.D.</u>				22d. ADDRESS <u>137 W. Washington St. Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/5/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel</u>				ADDRESS <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>DA NOV 7 '61</u>	
<u>Wm. C. Horst</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13141

13129

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Middleburg</b>	
c. LENGTH OF STAY IN b. <b>1 Day</b>		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>	
3. NAME OF DECEASED (Type or print) First <b>Ruth</b> Middle <b>Sprenkle</b> Last <b>Betts</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>2</b> Year <b>1961</b>	
5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <b>4/9/1889</b>		9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) <b>72 yrs.</b> Months <b>7</b> Days <b>2</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>J.C. Penney Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House Duties</b>	
11. BIRTHPLACE (Country & State, or foreign country) <b>Waynesboro, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Fred Frick</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Sprenkle</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>174-20-8203</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>Arterio Sclerotic + Hypertensive Cardio Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (b) <b>Syn+</b> (c) <b>Syn+</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> e.m. p.m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>May 58</b> 19 <b>61</b> to <b>2 AM</b> 19 <b>61</b> that (I) (we) last saw the deceased alive on <b>3 AM</b> 19 <b>61</b> and that death occurred at <b>2 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>F.F. Luby</b>		22b. DATE SIGNED <b>4/16/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>F.F. Luby</b>		22d. ADDRESS <b>2304 Potomast Hagerstown Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/6/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Green Hill</b>		23d. LOCATION (City, town or county) (State) <b>Waynesboro, Franklin Co., Pa.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Walter G. Lane, Waynesboro Pa.</b>		25. REC'D BY REGISTRAR <b>NOV 6 1961</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Prange</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. The law also requires that the death certificate be completed by the attending physician and completed by the funeral director. The law requires that the death certificate be completed by the attending physician and completed by the funeral director. The law requires that the death certificate be completed by the attending physician and completed by the funeral director.

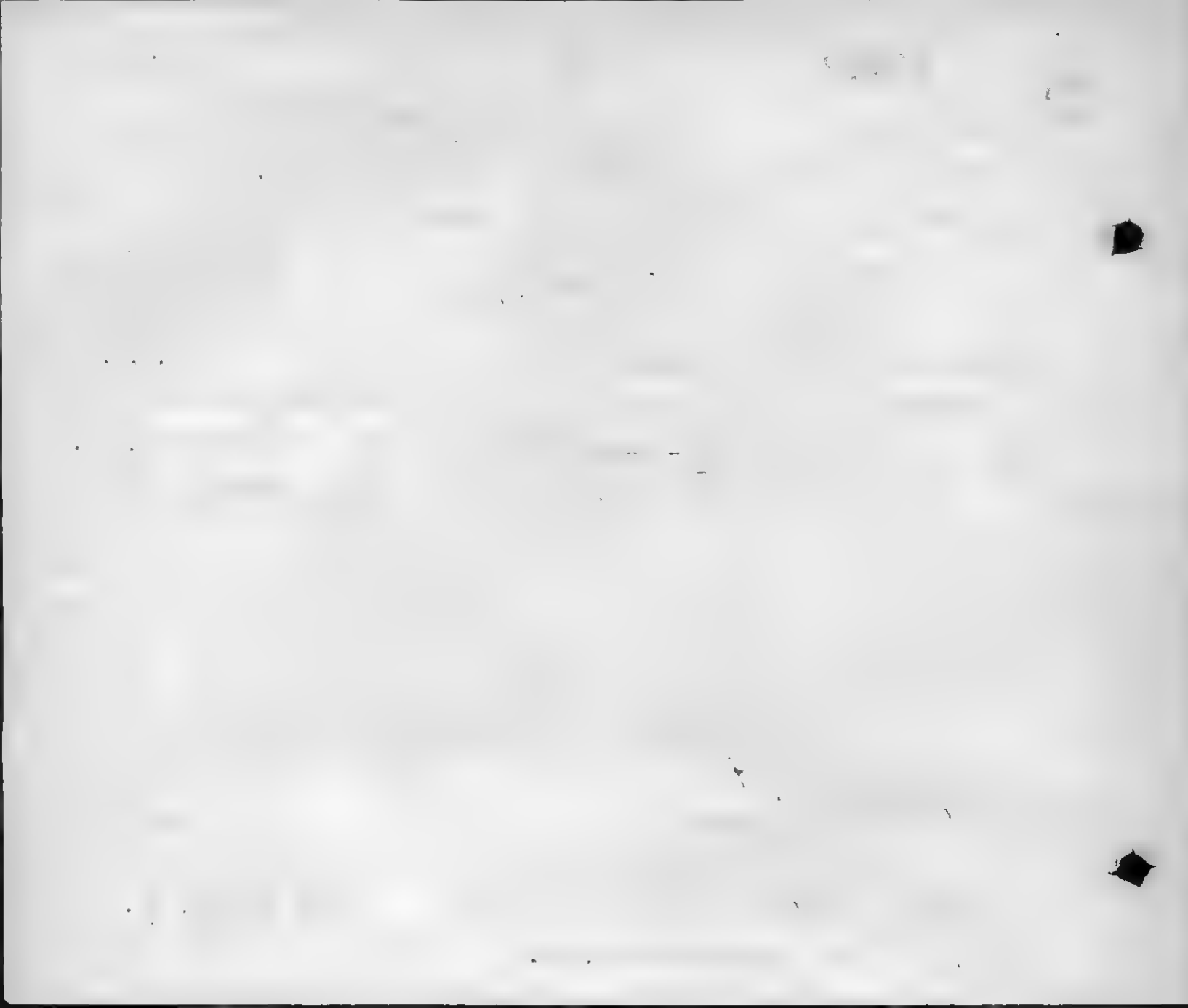
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. The law also requires that the death certificate be completed by the attending physician and completed by the funeral director. The law requires that the death certificate be completed by the attending physician and completed by the funeral director. The law requires that the death certificate be completed by the attending physician and completed by the funeral director.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13142											
13130											
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DOWNSVILLE ROAD</b> c. LENGTH OF STAY IN TB <b>5 YEARS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WARBURN BOARDING HOME</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CLEAR SPRING, MD.</b> d. STREET ADDRESS <b>NONE</b>						
3. NAME OF DECEASED (Type or print) <b>SAMUEL J. BLAIR</b>					4. DATE OF DEATH Month Day Year <b>11 / 4 / 1961</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/29/1886</b>		9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <b>8 5</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>		11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>DOWNEY BLAIR</b>					14. MOTHER'S MAIDEN NAME <b>ANNA ELIZABETH GWIER</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>					16. SOCIAL SECURITY NO. <b>214-14-6436</b>					17. INFORMANT Address <b>MRS RUTH MUNDEY, CLEAR SPRING, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Ac. MYOCARDIAL INFARCTION</b>					INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>CLEAR SPRING, MD.</b>					20g. (County) <b>CLEAR SPRING, MD.</b>					20h. (State) <b>CLEAR SPRING, MD.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>11/4/61</b> to <b>11/4/61</b> , that (I) (we) last saw the deceased alive on <b>11/4/61</b> , and that death occurred at <b>11/4/61</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Ralph F. Young</b>					22b. DATE SIGNED <b>11/6/61</b>						
22c. PHYSICIAN'S NAME (Type) <b>Ralph F. Young</b>					22d. ADDRESS <b>CLEAR SPRING, MD.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>					23b. DATE THEREOF <b>11/7/1961</b>					23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>	
23d. LOCATION (City, town or county) <b>CLEAR SPRING, MD.</b>					23e. (State) <b>CLEAR SPRING, MD.</b>						
24. FUNERAL DIRECTOR'S SIGNATURE <b>Margaret L. Lowland</b>					24a. ADDRESS <b>CLEAR SPRING, MD.</b>					25a. REC'D BY REGISTRAR <b>NOV 9 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>											



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

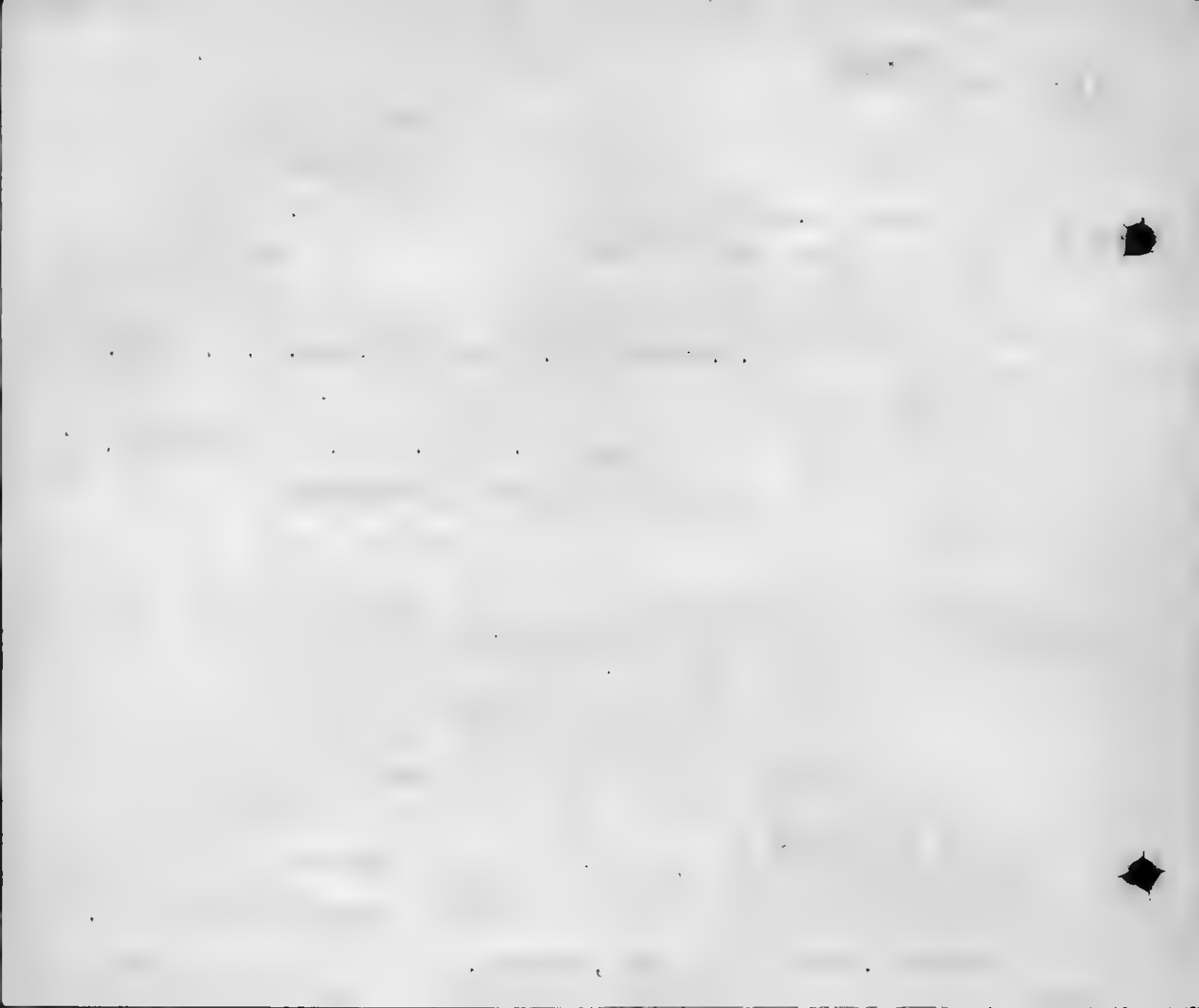
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## CERTIFICATE OF DEATH

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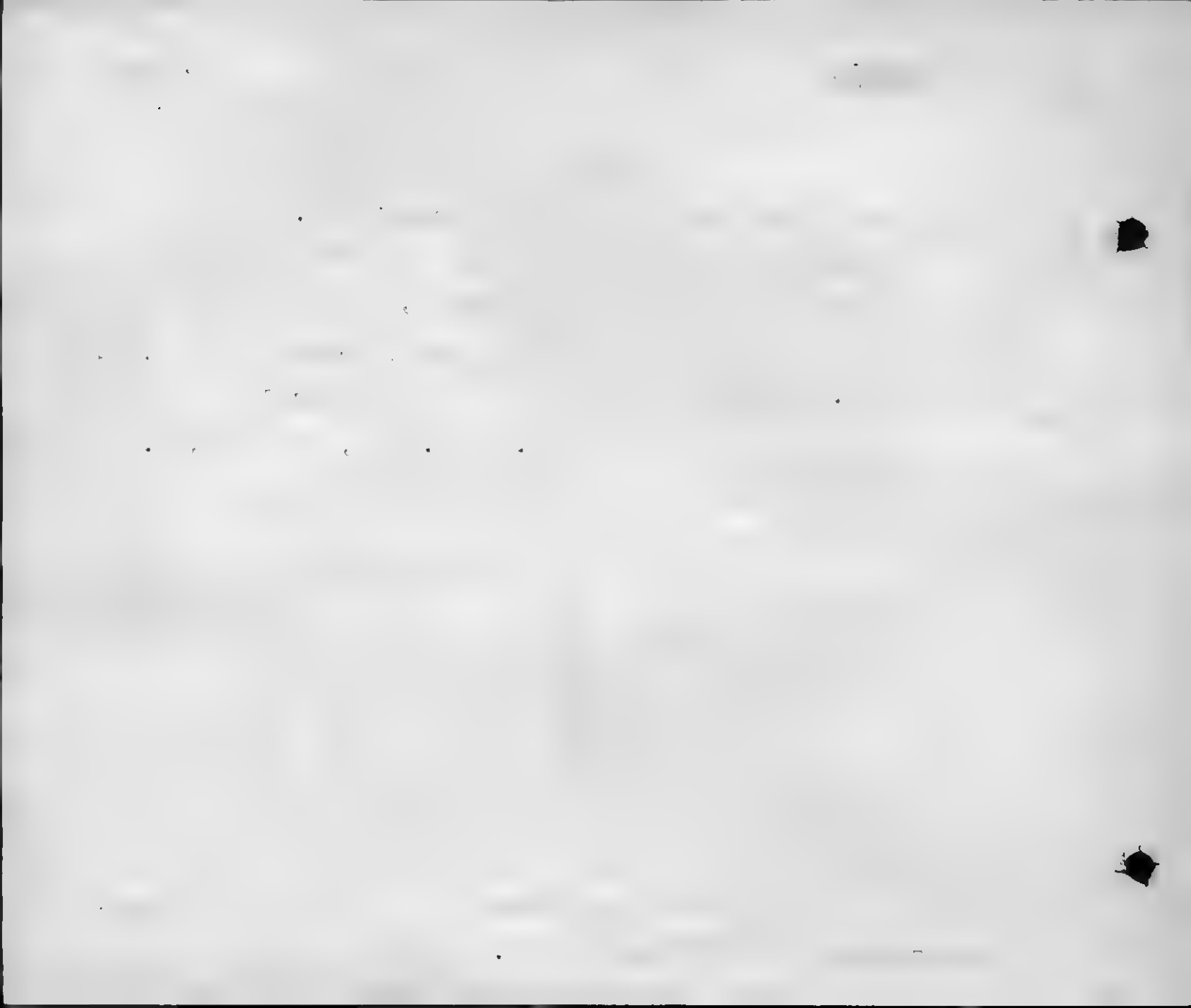
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Washington</b> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>1 week</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Co. Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>614 Sunset Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>EDGAR HARRY BLOOM</b>		<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>17</b> Year <b>19 61</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>April 14, 1885</b>
<b>9. AGE</b> (In years last birthday) <b>76</b> yrs.	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HRS.</b> Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>D.A. Stickell Co.</b>	
<b>11. BIRTHPLACE</b> (Country & State, or foreign country) <b>Hagerstown, Wash. Co. Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA.</b>	
<b>13. FATHER'S NAME</b> <b>Harry Bloom</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Elizabeth Myers</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>320-16-3854</b>	
<b>17. INFORMANT</b> <b>Mrs. Edna P. Bloom</b>		<b>Address</b> <b>Hagerstown, Maryland.</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <del>Arteriosclerotic Heart Disease</del> (b) <b>Rheumatic Heart Disease</b> (c) <b>Rheumatic fever - inactive</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Epileptiform seizures</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour a.m. _____ p.m. _____ <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ <b>(County)</b> _____ <b>(State)</b> _____			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Oct. 19 59</b> <b>to</b> <b>Nov. 17, 1961</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>Nov. 17, 1961</b> , <b>and that death occurred at</b> <b>9 A.M.</b> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>Lloyd A. Hoffner</b>		<b>22b. DATE SIGNED</b> <b>11/18/61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Lloyd A. Hoffner</b>		<b>22d. ADDRESS</b> <b>214 N. Potomac st.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>11/19/61</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Rose Hill Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) <b>Hagerstown, Maryland.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Andrew K. Coffman, Hagerstown, Maryland.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>NOV 21 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Christina L. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
CERTIFICATE OF DEATH			
13144			
1. PLACE OF DEATH a. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
c. LENGTH OF STAY IN 1b <b>8 years</b>		d. STREET ADDRESS <b>1905 Greenfield Rd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Western Maryland State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Emma Frances BLOOM</b>		4. DATE OF DEATH Month <b>11</b> Day <b>20</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 22, 1880</b>
9. AGE (In years last birthday) <b>81 yrs</b>		IF UNDER 1 YEAR Months <b>11</b> Days <b>20</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Maryland</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>George W. Mitchell</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Currell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>Mrs. Lynn L. Brown, Hagerstown, Md.</b>	
17. INFORMANT <b>Mrs. Lynn L. Brown, Hagerstown, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobular pneumonia</b> <b>Diabetes mellitus</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <b>Hypertensive cardiovascular disease, coronary arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>33 years</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 23, 1960</b> to <b>Nov. 20, 1961</b> , that (I) <del>(we)</del> saw the deceased alive on <b>Nov. 20, 1961</b> , and that death occurred at <b>P. M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Young E. Chun</b> M.D.		22b. DATE SIGNED <b>Nov. 20, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>YOUNG E. CHUN</b>		22d. ADDRESS <b>1500 pen na. Ave Hagerstown, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/22/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Suter - Rouzer Funeral Home</b>		25a. REC'D BY REGISTRAR <b>DA NOV 27 '61</b>	
ADDRESS <b>Hagerstown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>William L. Thomas</b>	

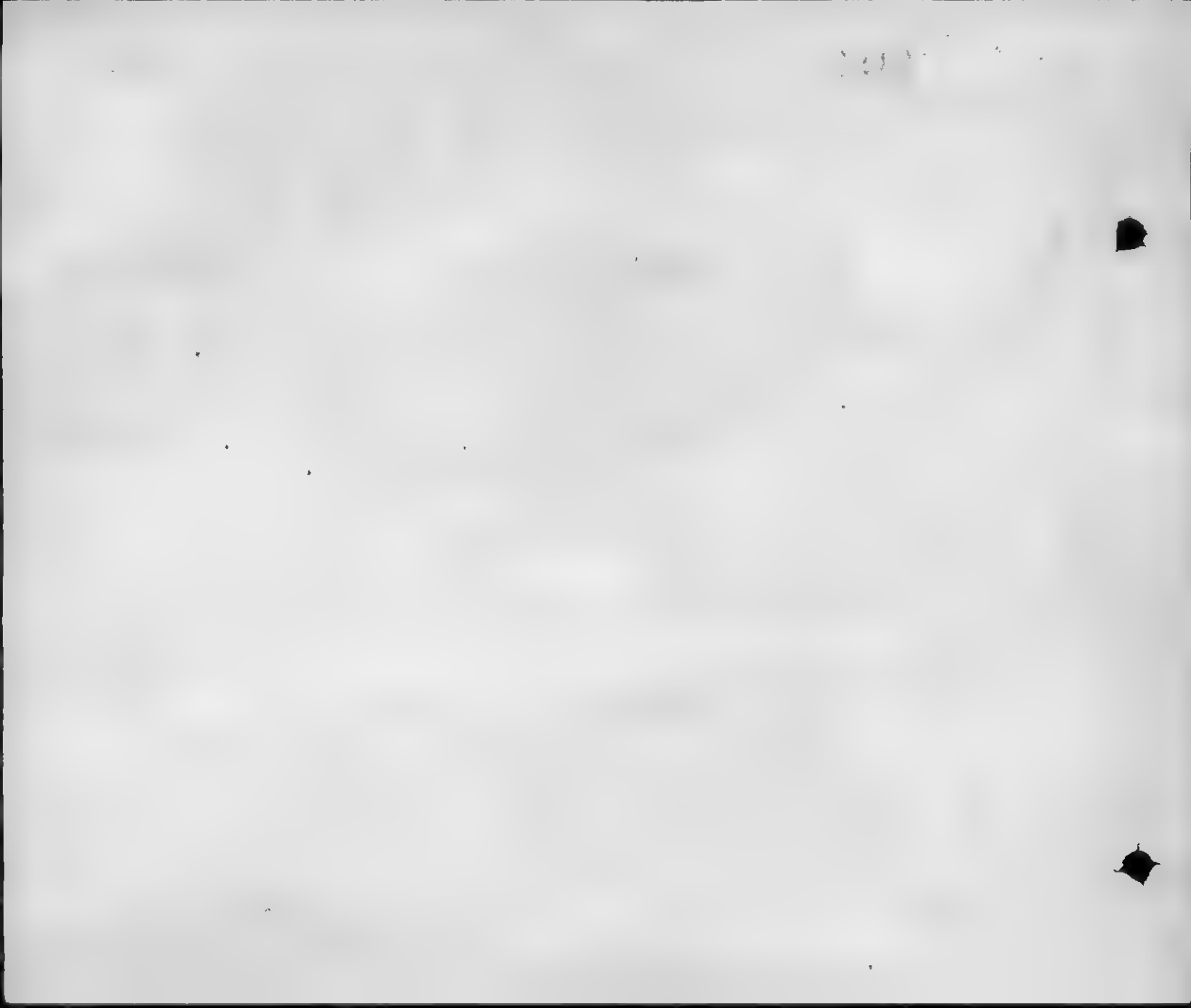


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13145 CERTIFICATE OF DEATH 13133									
Item 9 rain G-01 11/24/61 iwk									
1. PLACE OF DEATH a. COUNTY <b>Washington</b>		b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>35 Yrs</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>356 East Franklin St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>356 East Franklin St</b>		4. DATE OF DEATH Month <b>November</b> Day <b>18</b> Year <b>1961</b>			
3. NAME OF DECEASED (Type or print) <b>MARY ELIZABETH BOWERS</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb 10 1893</b> AGE (In years last birthday) <b>68</b> y	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State or foreign country) <b>Hagerstown Wash Co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Charles E. Springer</b>		14. MOTHER'S M A DEN NAME <b>No Record</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>George E. Bowers Sr</b> Address <b>356 E. Franklin St Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerosis</b> (a), stating the underlying cause last. DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <b>11/18/61</b> to <b>11/18/61</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>11/20/61</b> , 19 <b>61</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Robert V. Campbell</b> 22b. DATE SIGNED <b>11/29/61</b>									
22c. PHYSICIAN'S NAME (Type) <b>ROBERT V. Campbell</b> 22d. ADDRESS <b>Hagerstown Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>11/20/61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>Hagerstown Wash Co Md</b>									
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b> ADDRESS <b>Hagerstown Md</b> 25a. REC'D BY REGISTRAR <b>NOV 21 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Andrew S. Kline</b>									



21  
FOR STATE  
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

13146

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13134

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN <b>Hagerstown Maryland</b> c. LENGTH OF STAY IN 1b <b>life time</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Maryland.</b> d. STREET ADDRESS <b>218 N Jonathan Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Arnold Darnell Broadus</b>		4. DATE OF DEATH <b>11 28 19 61</b>		5. SEX <b>Male</b> 6. COLOR OR RACE <b>Colored</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <b>11-19-1959</b>		9. AGE (In years last birthday) <b>2</b> yrs.		10. IF UNDER 1 YEAR: Months <b>11</b> Days <b>28</b> Hours <b>19</b> Min. <b>61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		13. FATHER'S NAME <b>Harris Baker</b>		14. MOTHER'S MAIDEN NAME <b>Bertrice D. Broadus.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>none</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Bertrice D. Broadus.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Splenic Hemorrhage</b> DUE TO (b) <b>Cerebral Edema</b> DUE TO (c) <b>Myocardial Infarction</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), (b), OR (c), STATING THE UNDERLYING CAUSE LAST.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <b>Support &amp; have fallen on floor of home</b>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY (a) OR CONTRIBUTING (b) CAUSE OF DEATH. <b>Support &amp; have fallen on floor of home</b>					
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Support &amp; have fallen on floor of home</b>					
20c. TIME OF INJURY Month, Day, Year <b>4 11-27-61</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b> 20f. (City or town) <b>Hagerstown</b> (County) <b>Washington</b> (State) <b>MD</b>					
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>[Signature]</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>D. E. W. [Signature]</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>11/30/61</b>					
Address (Street, city, town, or county) <b>[Address]</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>12-3-1961</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Piney Grove Cemetery</b> 22d. LOCATION (City, town, or country) <b>Piney Grove, Maryland</b>					
23. FUNERAL DIRECTOR <b>John R. Watson Jr. Hagerstown Md</b> 24a. REC'D BY REG. STRAR <b>DEC 5 '61</b> 24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 Filed 301  
 11-21-61 ams  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
 13147  
 CERTIFICATE OF DEATH  
 13135

1. PLACE OF DEATH  
 a. COUNTY Washington  
 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown  
 c. LENGTH OF STAY IN 1b md  
 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Western md St. Joseph

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
 a. STATE md  
 b. COUNTY Washington  
 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown  
 d. STREET ADDRESS md

3. NAME OF DECEASED  
 (Type or print) VICIE ANN BROWN

4. DATE OF DEATH  
 Month Nov Day 11 Year 1961

5. SEX F 6. COLOR OR RACE C 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH 10-26-79 9. AGE (In years last birthday) 82 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.  
 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker 10b. KIND OF BUSINESS OR INDUSTRY none 11. PLACE (County & State, or foreign country) Shoptown 12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME Geo. Brown 14. MOTHER'S MAIDEN NAME Elizabeth Hubbard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? no 16. SOCIAL SECURITY NO. none 17. INFORMANT Robert Brown Address Hagerstown

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
 PART I DEATH WAS CAUSED BY:  
 IMMEDIATE CAUSE (a) LOBULAR PNEUMONIA  
 420.0 DUE TO  
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CONGESTIVE HEART FAILURE  
 DUE TO (c) Arteriosclerotic heart disease

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PYELITIS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 11-11-1961 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (Name of physician) attended the deceased from 10-6-1961 to 11-11-1961, that (I) no last saw the deceased alive on 11-11-1961, and that death occurred at 2 PM, from the causes and on the date stated above.

22a. SIGNATURE Antonio U. Pallacrosi M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒ 22b. DATE SIGNED  
 22c. PHYSICIAN'S NAME (Type) ANTONIO U. PALLACROSI 22d. ADDRESS 1500 Pa Ave Hagerstown

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 11-15-61 23c. NAME OF CEMETERY OR CREMATORY Shoptown Cem 23d. LOCATION (City, town or county) Shoptown md (State)

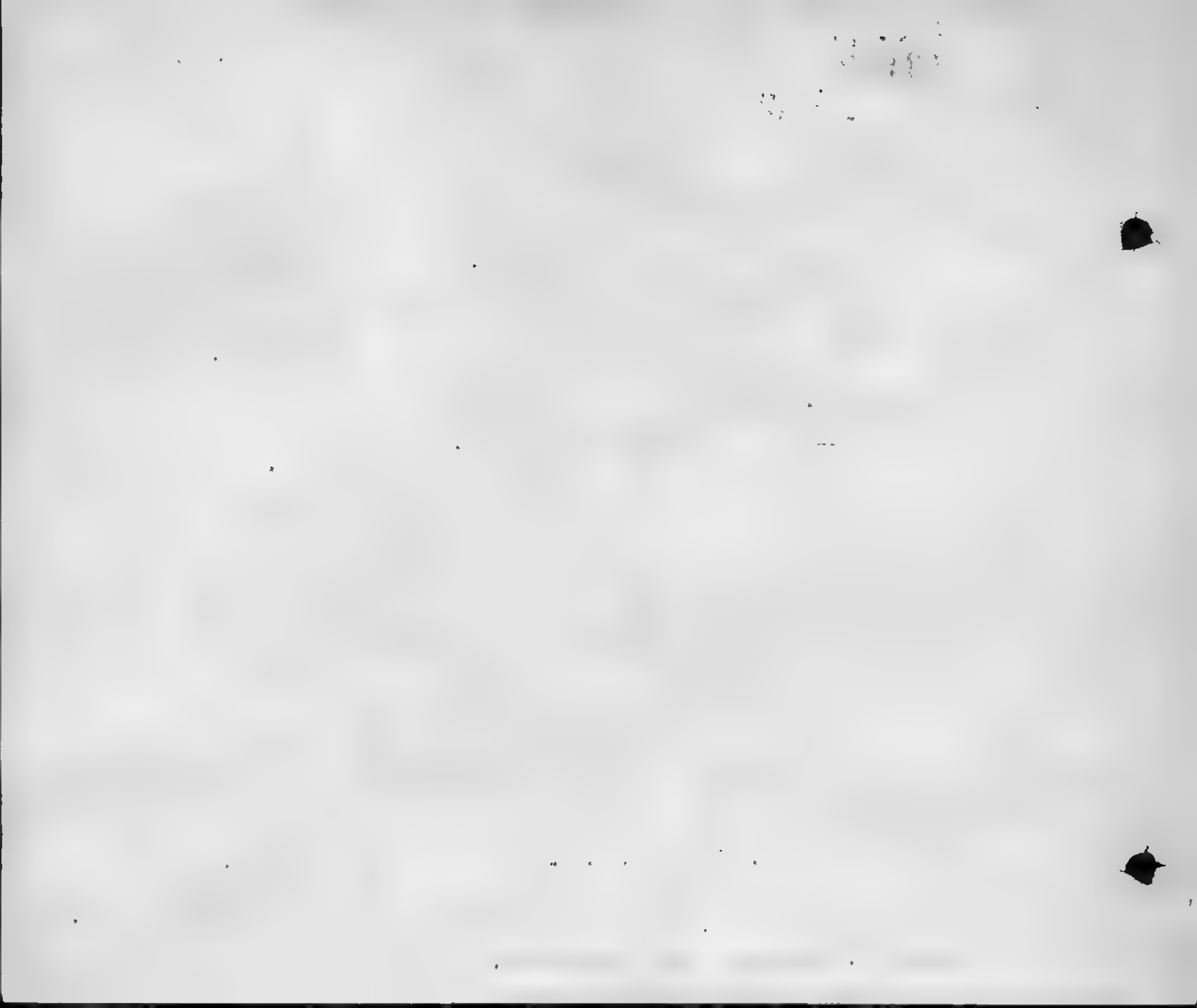
24. FUNERAL DIRECTOR'S SIGNATURE Brooker M. West Address Paledium md 25a. REC'D BY REGISTRAR NOV 17 '61 25b. REGISTRAR'S SIGNATURE Carl S. Kraus



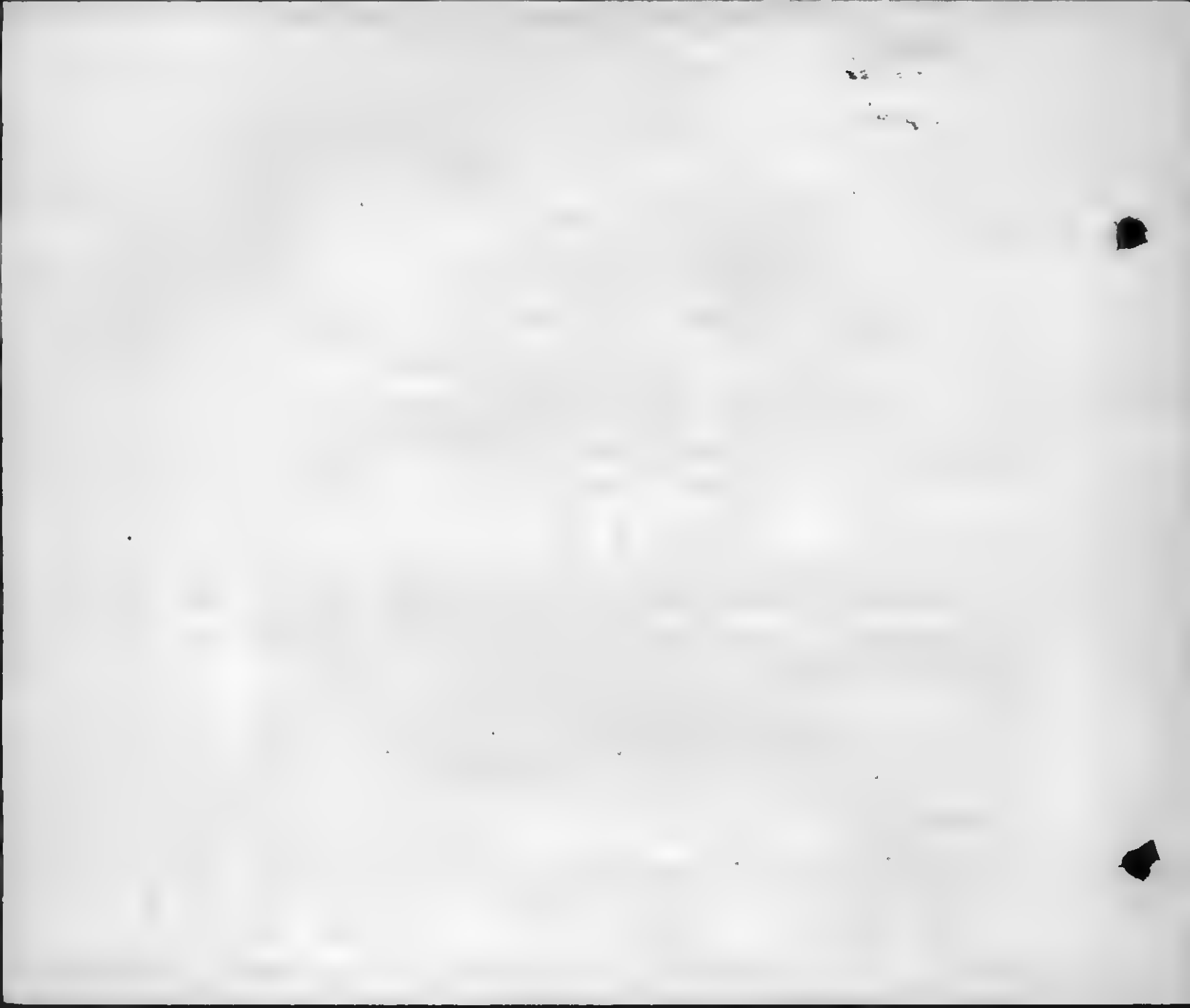
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
13148  
CERTIFICATE OF DEATH  
13136

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY N b <b>10 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Martin Manor Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>320 No Prospect St</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ELIZABETH FRANCES CARPER</b>		4. DATE OF DEATH <b>November 26 1961</b>	
5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>Apr 21 1876</b>	
9. AGE (In years last birthday) <b>85 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Winchester Fred Co Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George W. Grubbs</b>		14. MOTHER'S MAIDEN NAME <b>Fannie Newcome</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Harry E. Osborne</b>		Address <b>320 No Prospect St Hagerstown Md.</b>	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>9-11 Hemorrhage from esophageal varices</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Ht. hemiplegia due to gen/arteriosclerosis + cerebral arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>30 Min.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 6</b> , 1961, to <b>Nov 26</b> , 1961, that (I) (we) last saw the deceased alive on <b>Nov 26</b> , 1961, and that death occurred at <b>4 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Edward W. Ditto III</b>		22b. DATE SIGNED <b>11/27/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edward W. Ditto III, M. D.</b>		22d. ADDRESS <b>217 West Washington St.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/29/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hagerstown Wash Co Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		25a. REC'D BY REGISTRAR <b>NOV 29 '61</b>	
ADDRESS <b>Hagerstown Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u></p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SAN MAR. RURAL</u></p> <p>c. LENGTH OF STAY IN 1b <u>6 MONTHS</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>STAIRNEY-KEEDY MEMORIAL HOME</u></p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</p> <p>a. STATE <u>NEW YORK</u> b. COUNTY <u>DUTCHESS COUNTY</u></p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WAPPINGERS FALLS</u></p> <p>d. STREET ADDRESS <u>61X 3</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print)</p> <p>First <u>FRANKIE</u> Middle <u>E.</u> Last <u>CORBIN</u></p>		<p>4. DATE OF DEATH</p> <p>Month <u>NOVEMBER</u> Day <u>25</u> Year <u>1961</u></p>	
<p>5. SEX <u>FEMALE</u></p> <p>6. COLOR OR RACE <u>WHITE</u></p> <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>JANUARY 25 1882</u></p> <p>9. AGE (In years last birthday) <u>79</u> yrs. <u>10</u> months <u>0</u> days <u>0</u> hours <u>0</u> min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u></p> <p>10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u></p>		<p>11. BIRTHPLACE (County &amp; State, or foreign country) <u>BROOKLYN N.Y.</u></p> <p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>	
<p>13. FATHER'S NAME <u>THOMAS JEFFERSON SADDINGTON</u></p> <p>14. MOTHER'S MAIDEN NAME <u>EMILY BRADY</u></p>		<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)</p> <p>16. SOCIAL SECURITY NO. <u>4100-32ND ROAD, SOUTH ARLINGTON G. VA.</u></p> <p>17. INFORMANT <u>MRS. MARJORIE I. ROSS</u></p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intestinal Obstruction</u></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Paralytic Ileus</u></p> <p>(c) <u>Coronary Thrombosis</u></p>		<p>INTERVA. BETWEEN ONSET AND DEATH</p> <p><u>18 day</u></p> <p><u>8 day</u></p> <p><u>1 yr</u></p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>		<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</p>	
<p>20c. TIME OF INJURY Month, Day, Year</p> <p>Hour a.m. p.m. <u>19</u></p>		<p>20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work</p>	
<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that (I) (this hospital) attended the deceased from <u>Nov 1</u> 19<u>61</u> to <u>Nov 25</u> 19<u>61</u>, that (I) (we) last saw the deceased alive on <u>Nov 24</u> 19<u>61</u>, and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above.</p>			
<p>22a. SIGNATURE <u>[Signature]</u></p> <p>22c. PHYSICIAN'S NAME (Type) <u>B. Wheeler</u></p>		<p>22b. ADDRESS <u>Boonsboro, Md.</u></p> <p>22d. ADDRESS <u>Boonsboro, Md.</u></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u></p>		<p>23b. DATE THEREOF <u>NOV. 28 1961</u></p>	
<p>23c. NAME OF CEMETERY OR CREMATORY <u>WAPPINGER FALLS CEMETERY</u></p>		<p>23d. LOCATION (City, town or county) (State) <u>WAPPINGER FALLS N.Y.</u></p>	
<p>24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u></p>		<p>25a. REC'D BY REGISTRAR <u>[Signature]</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u></p>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

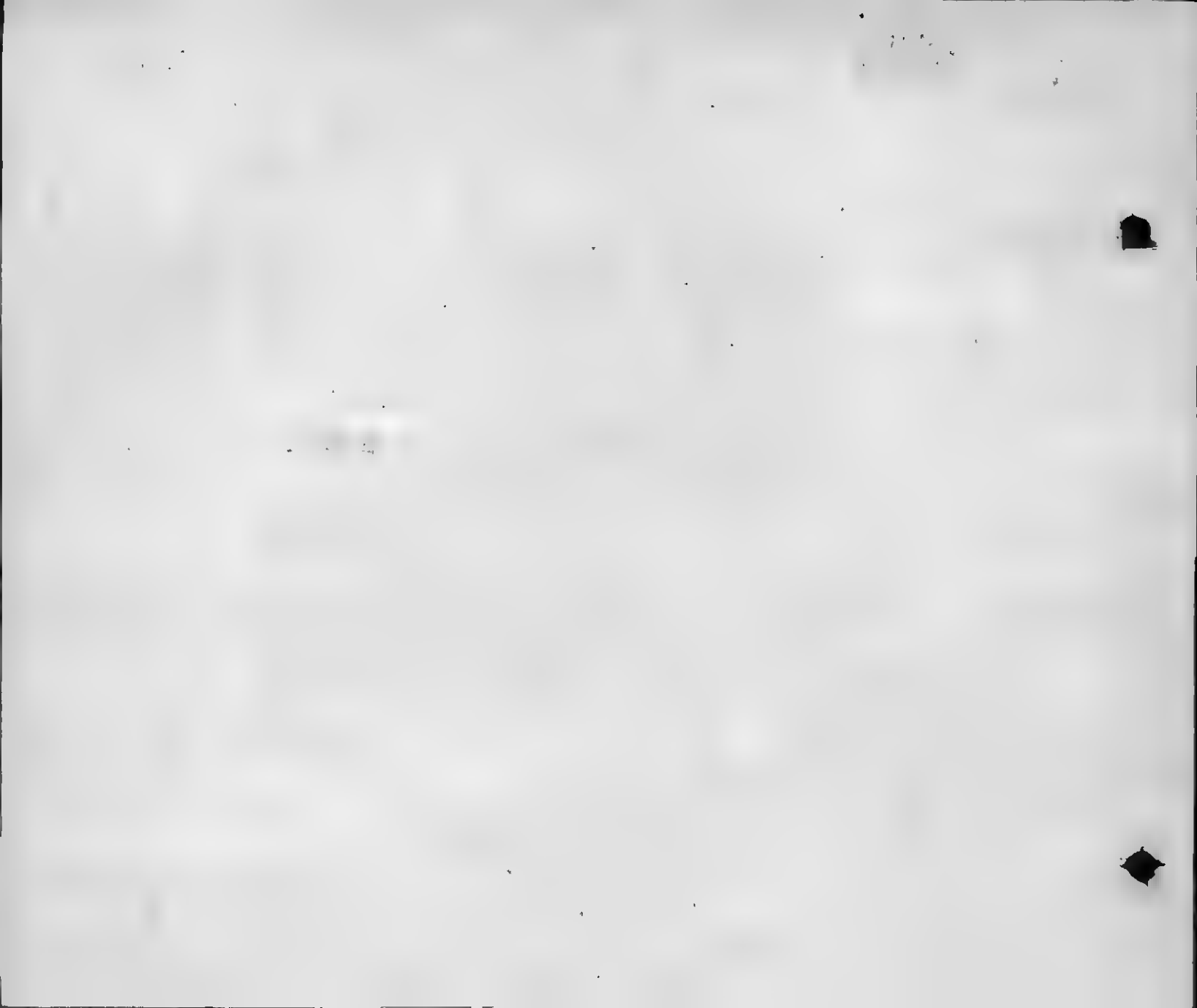
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13131

13139

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Smithburg</u> c. LENGTH OF STAY IN 1b <u>—</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RD 2 - Smithburg, md.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Wash.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Smithburg</u> d. STREET ADDRESS <u>RD 2 - Smithburg, md.</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>RAYMOND G. CORDELL</u> 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		4. DATE OF DEATH <u>NOV 13 1961</u> 9. AGE (In years) (If UNDER 1 YEAR, last birthday) <u>63</u> yrs. Months Days Hours Min. <u>—</u>	
11. BIRTH PLACE (County & State, or foreign country) <u>St. Thomas, Pa.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Franc Cordell</u> 14. MOTHER'S MAIDEN NAME <u>M. Elizabeth Holstay</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>Mrs. Hazel Cordell</u> (If yes, give war or dates of service)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>157X</u> DUE TO <u>le arcinoma of</u> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>le arcinoma of pancreas</u> (c) <u>le arcinoma of Lungs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a. <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>10 mos</u> <u>3 mos</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Hour a.m. p.m. Month Day Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 10, 1961</u> to <u>Nov 13, 1961</u> , that (I) (we) last saw the deceased alive on <u>Nov 13, 1961</u> , and that death occurred at <u>4:45 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>G. A. Kohler</u>		22b. DATE SIGNED <u>11/14/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. A. KOHLER</u>		22d. ADDRESS <u>Smithsburg and</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u>		23b. DATE THEREOF <u>11/16/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Hill Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Cosbytown, Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Minnich</u>		25a. REC'D BY REGISTRAR <u>—</u> 25b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>NOV 17 1961</u>		—	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

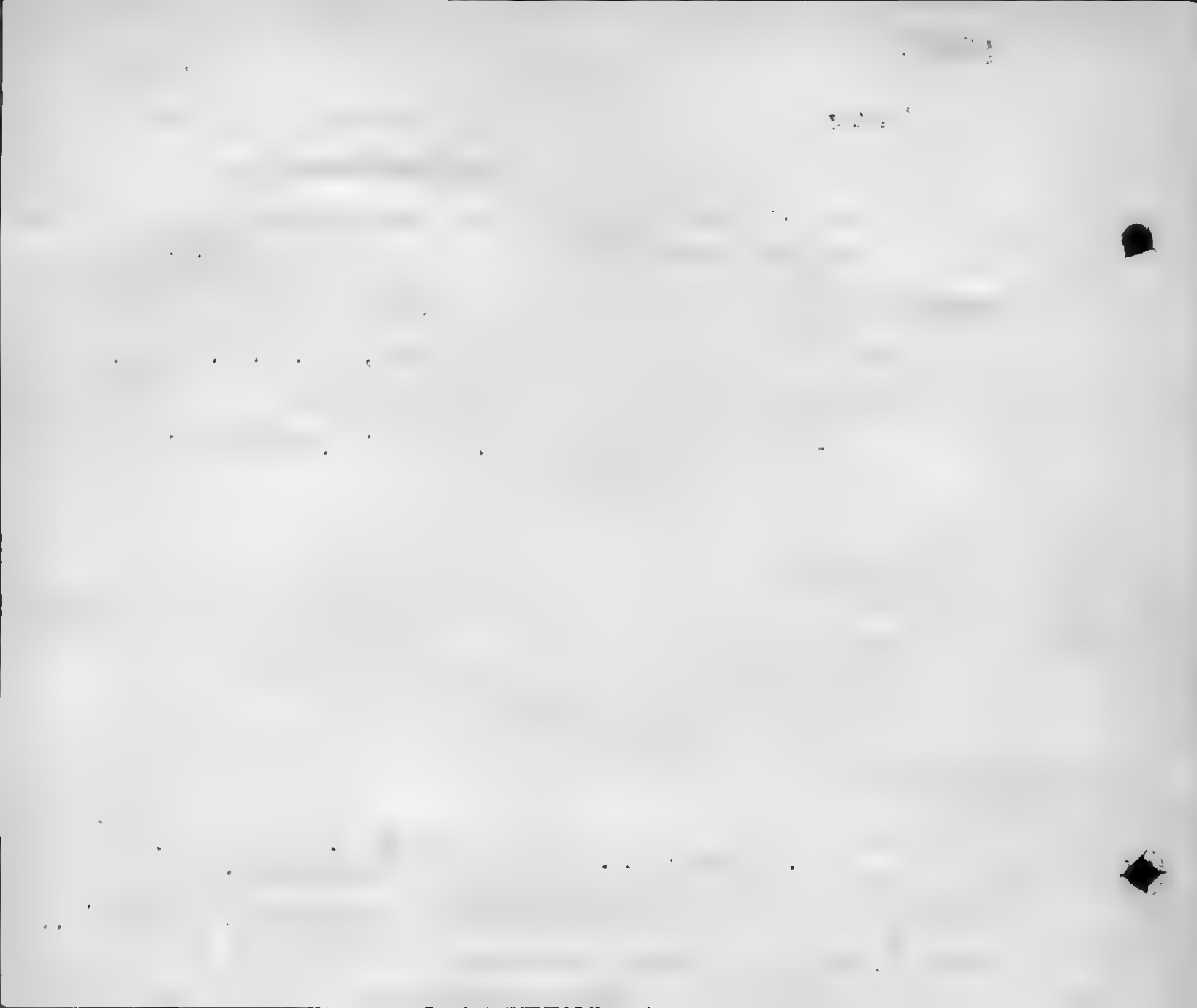
# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

131152

13140

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Washington</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>4 hrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Co. Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institut on: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>130 Clearview Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>FONROSE WISNER COSEY</b> First Middle Last <b>4. DATE OF DEATH</b> <b>November 6 1961</b> Month Day Year				<b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>April 19, 1901</b> <b>9. AGE</b> (In years last birthday) <b>60</b> yrs. If UNDER 1 YEAR: Months Days If UNDER 24 HRS.: Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Salesman</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Hagerstown, Wash. Co. Md.</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA.</b>				<b>13. FATHER'S NAME</b> <b>Daniel Cosey</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Catherine Fox</b> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> <b>16. SOCIAL SECURITY NO.</b> <b>215-09-7296 A</b> <b>17. INFORMANT</b> <b>Mrs. Virginia K. Cosey, 130 Clearview Rd. Hagerstown, Md.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable acute ventricular fibrillation with</b> <b>1201</b> DUE TO <b>cardiac arrest</b> Conditions, if any, which gave rise to immediate cause (b) <b>Coronary heart disease (myocardial infarct Nov 1960)</b> (a), stating the underlying cause last. DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18)				<b>20c. TIME OF INJURY</b> Hour e.m. p.m. <b>19</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>2-15-1952</b> <b>to</b> <b>11-6-1961</b> , that (I) (we) last saw the deceased alive on <b>11-6-1961</b> , and that death occurred at <b>5:30 p.m.</b> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>John H. Hornbaker</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>John H. Hornbaker, M.D.</b>				<b>22b. DATE SIGNED</b> <b>11-7-61</b> <b>22d. ADDRESS</b> <b>154 W. Washington St., Hagerstown, Md.</b> <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b> <b>23b. DATE THEREOF</b> <b>11/9/61</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Edge Hill Cemetery</b> <b>23d. LOCATION (City, town or county)</b> <b>Charlestown, Virginia.</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Andrew K. Coffman, Hagerstown, Maryland</b>				<b>25a. REC'D BY REGISTRAR</b> <b>NOV 10 '61</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kline</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director. After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

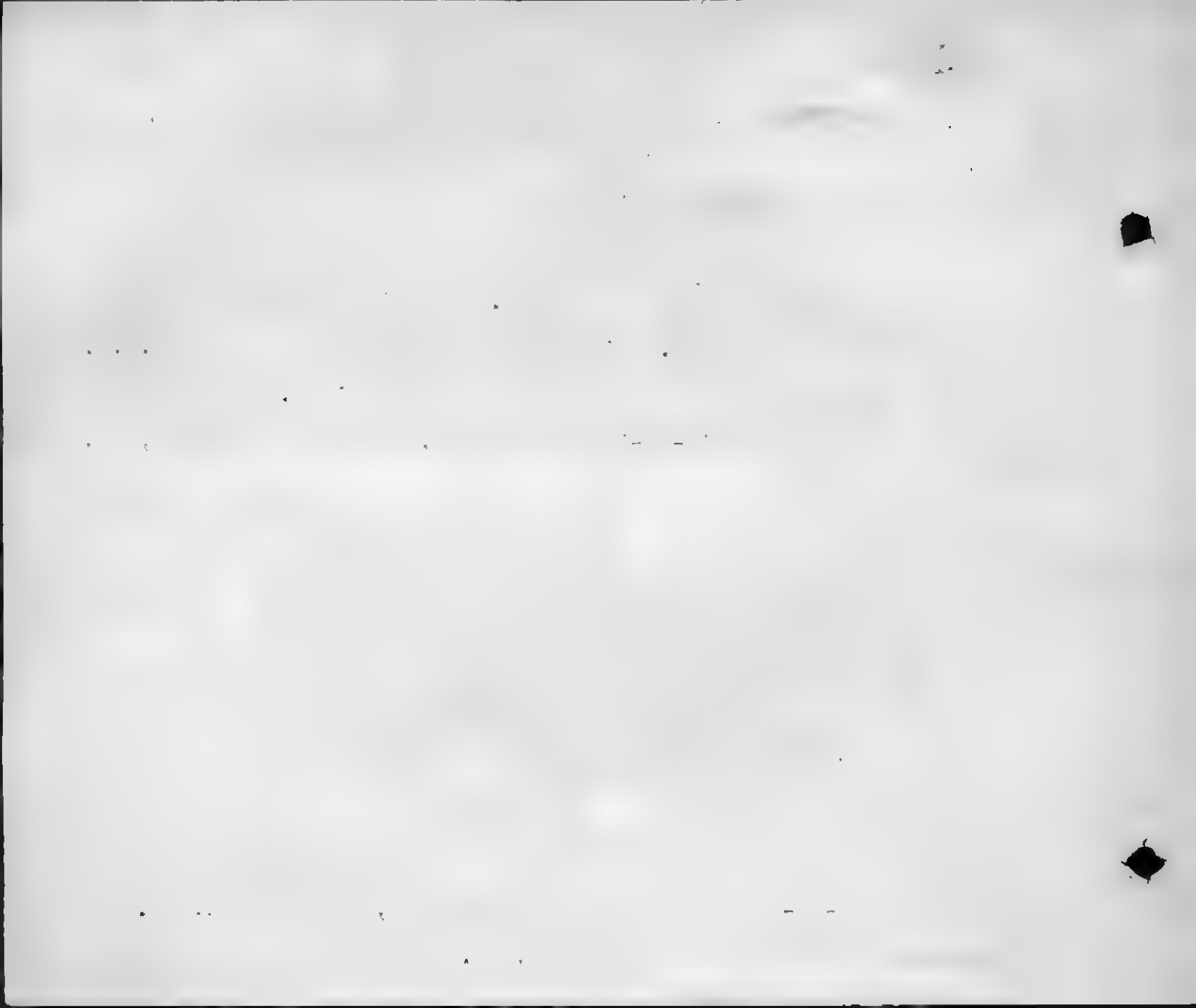
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

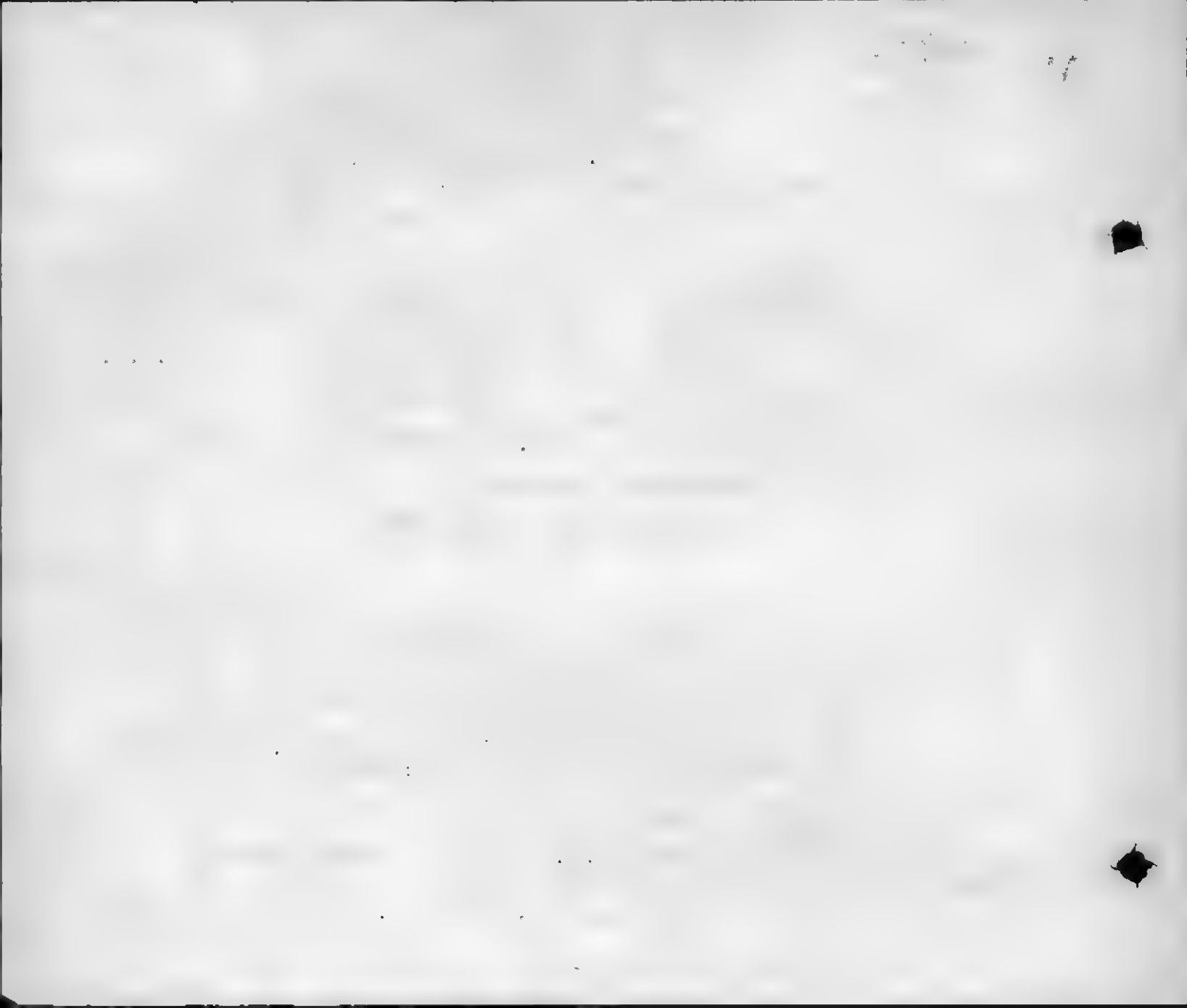
13153

13141

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Washington</b> b. CITY OR TOWN <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>16 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Western Maryland State Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if not in 1a: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Thurmont rural</b> d. STREET ADDRESS <b>RD 1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>HATTIE VIOLA DAYHOFF</b> 5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Fred. Tailoring Maryland</b> 11. BIRTHPLACE (Country & State, or foreign country) <b>U.S.A.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		<b>4. DATE OF DEATH</b> <b>NOV 10 1961</b> 9. AGE (In years, if under 1 year, if under 24 hrs.) <b>46</b> 13. FATHER'S NAME <b>James Few</b> 14. MOTHER'S MAIDEN NAME <b>Mettie B. Shelton</b> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> 16. SOCIAL SECURITY NO. <b>215-14-1047</b> 17. INFORMANT <b>Eugene A. Dayhoff</b> Address <b>Thurmont, Md. RD 1</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF CERVIX RECURRENT</b> 171X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>LEFT MYDRONEPHROSIS</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR</b>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (who is <del>not</del> deceased) attended the deceased from <b>10-25-1961</b> to <b>11-10-1961</b>, that (I) last saw the deceased alive on <b>11-10-1961</b>, and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>Antonio U. Pallagrosi</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>ANTONIO U. PALLAGROSI</b>		<b>22b. DATE SIGNED</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>22d. ADDRESS</b> <b>1500 Pa Ave Hagerstown Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b> <b>23b. DATE THEREOF</b> <b>11-13-61</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Church of Brethern Cem, Rocky Ridge, Md.</b> <b>23d. LOCATION (City, town or county)</b> (State)		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Raymond E. Quager</b> ADDRESS <b>Thurmont, Md.</b> <b>25a. REC'D BY REGISTRAR</b> <b>NOV 14 '61</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur E. Kraus</b>	





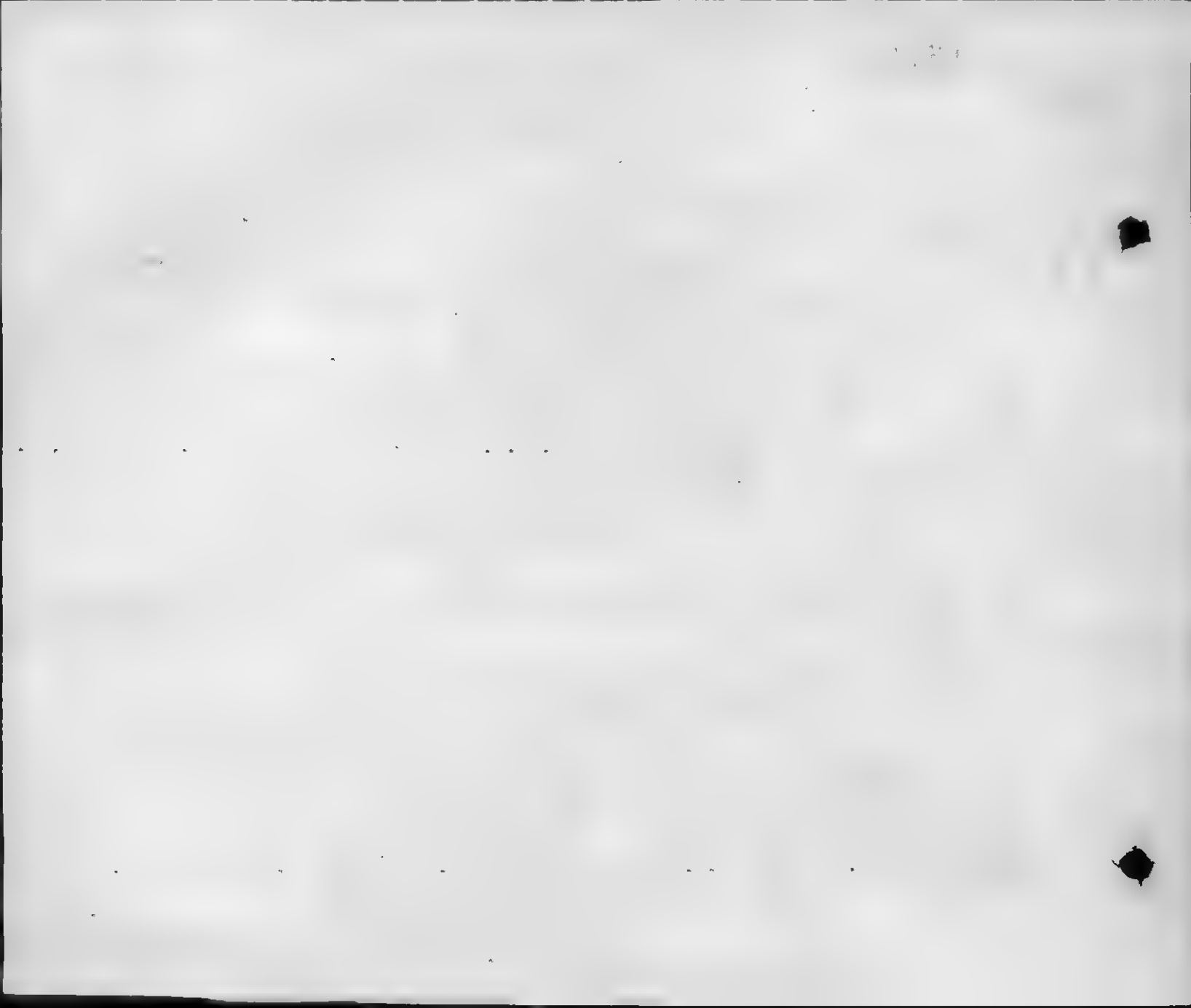


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13155 CERTIFICATE OF DEATH 13143									
1. PLACE OF DEATH a. COUNTY <u>Washington</u>					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>					c. LENGTH OF STAY N 1b <u>Life</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>					f. STREET ADDRESS <u>58 Randolph Ave.</u>				
3. NAME OF DECEASED (Type or print) First <u>Eliza</u> Middle <u>Pearl</u> Last <u>Dieterich</u>					4. DATE OF DEATH Month <u>November</u> Day <u>27</u> Year <u>1961</u>				
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u>					7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>				
8. DATE OF BIRTH <u>September 14, 1896</u>					9. AGE (In years last birthday) <u>65</u> yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					11. BIRTHPLACE (County & State, or foreign country) <u>Williamsport, Md.</u>				
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					13. FATHER'S NAME <u>Charles Cottrill</u>				
14. MOTHER'S MAIDEN NAME <u>Molly Shank</u>					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>				
16. SOCIAL SECURITY NO. <u>1214-09-2630</u>					17. INFORMANT <u>Mr. Wm. U. Dieterich 58 Randolph Ave. Hagerstown, Md.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Colon, polypoid</u> <u>153.8</u> DUE TO (b) <u>With generalized metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>3 mm x 1</u>					INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 26</u> , 19 <u>61</u> to <u>Nov. 27</u> , 19 <u>61</u> ; that (I) (we) last saw the deceased alive on <u>Nov. 27</u> , 19 <u>61</u> , and that death occurred <u>Nov. 27</u> , 19 <u>61</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>L. L. Packer</u> M.D.					22b. DATE SIGNED <u>11/27/61</u>				
22c. PHYSICIAN'S NAME (Type) <u>L. L. Packer M.D.</u>					22d. ADDRESS <u>145 W. Washington St. Hagerstown, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>11/30/61</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>					23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel</u>					25a. REC'D BY REGISTRAR <u>NOV 29 61</u>				
25b. REGISTRAR'S SIGNATURE <u>Wm. G. Shank</u>									



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13156

## CERTIFICATE OF DEATH

13144

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> c. LENGTH OF STAY IN 1b <u>6 month</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Williamsport Sanitarium</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> <u>R#3</u> d. STREET ADDRESS <u>Rural Hagerstown RFD #3</u>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>ELISHA Columbus Dorsey</u>		<b>4. DATE OF DEATH</b> Day <u>Nov</u> Month <u>23</u> Year <u>1961</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>									
<b>8. DATE OF BIRTH</b> <u>12-4-1895</u>		<b>9. AGE</b> (In years last birthday) <u>65</u> yrs. <table border="1"> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td><u>11</u></td> <td><u>18</u></td> <td></td> <td></td> </tr> </table>		Months	Days	Hours	Min.	<u>11</u>	<u>18</u>			<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Ret'd Farm Owner</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farm</u>	
Months	Days	Hours	Min.										
<u>11</u>	<u>18</u>												
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Downsville MD</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>EDWARD P. Dorsey</u>									
<b>14. MOTHER'S MAIDEN NAME</b> <u>SARAH DANNER</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>									
<b>17. INFORMANT</b> <u>Carl Dorsey 2204 Gay St. Hagerstown Md.</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke (Cerebral Hemorrhage)</u> (b) <u>Atherosclerosis</u> (c) <u>Previous stroke</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m.									
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)									
<b>21. I certify that (I) (this hospital) attended the deceased from May 1961 to Nov 22 1961 that (we) last saw the deceased alive on Nov 20 1961, and that death occurred at 3:30 PM, from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <u>M.E. Byrkit</u>		<b>22b. DATE SIGNED</b> <u>11-23-61</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Williamsport Md</u>									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Nov. 26-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Manor Cemetery</u>									
<b>23d. LOCATION</b> (City, town or county) (State) <u>Near Tighmanton Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>NOV 27 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>									

TO FURNISH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FURNISH OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1000



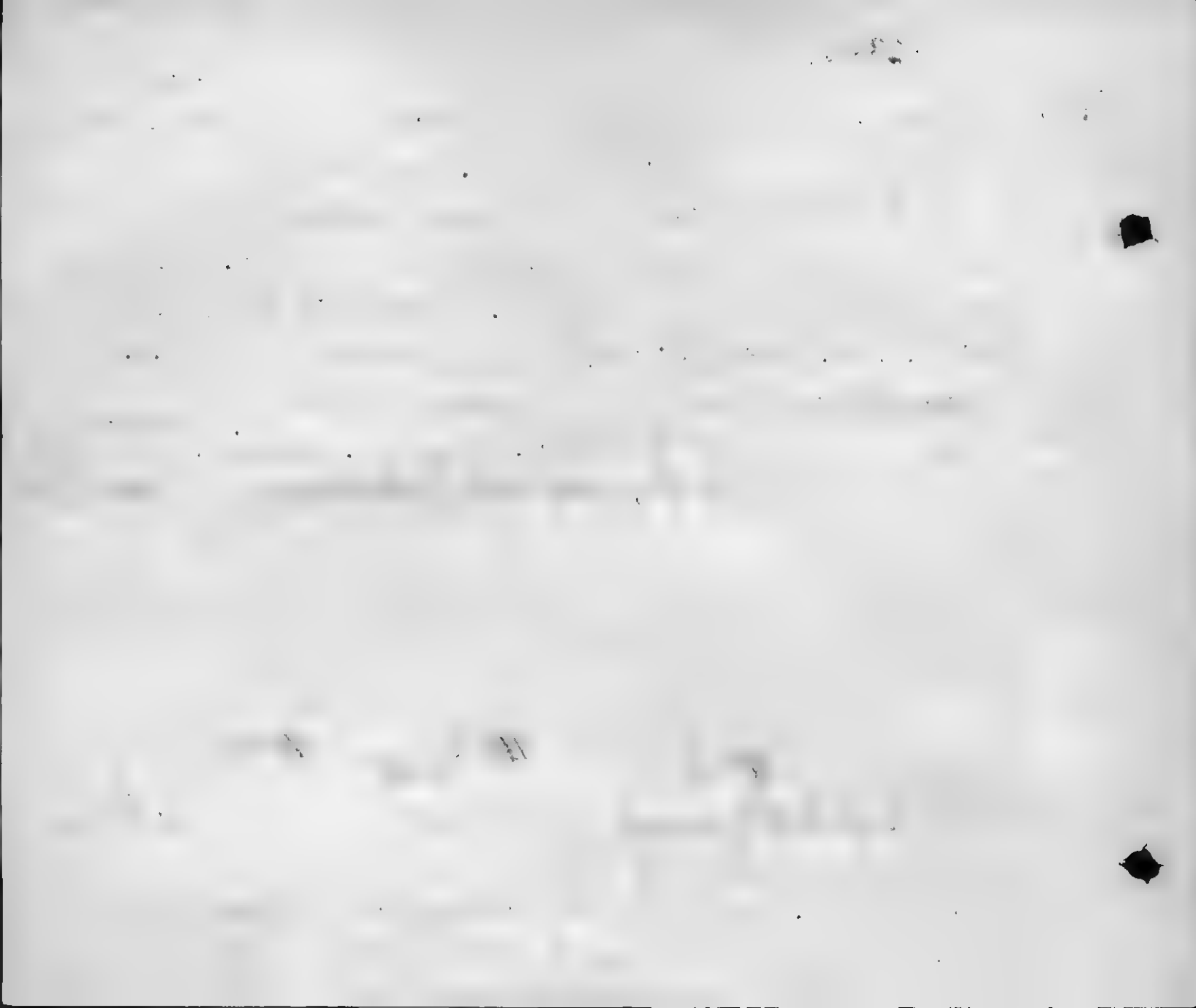
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
13157											
13145											
1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>1 week</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. James Village</b> d. STREET ADDRESS <b>Sharpsburg Pike</b>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>Frank Leslie Earnshaw</b>						4. DATE OF DEATH Month Day Year <b>Nov. 11 19 61</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 10 1887</b>		9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <b>3 1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret'd U.S. Gov. Clerk Agriculture</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. of Agriculture</b>					
11. BIRTHPLACE (Country & State or foreign country) <b>Maryland</b>						12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>John Francis Earnshaw</b>						14. MOTHER'S MAIDEN NAME <b>Rosetta Glover</b>					
15. WAS DECEASED IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>						16. SOCIAL SECURITY NO. 17. INFORMANT <b>215 36 6871 Mrs. Margaret L. Earnshaw</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>Ac Myocardial Infarction</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> <b>Immediate</b>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>MI</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>11/11/61</b>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>MI</b>						20f. (City or town) (County) (State) <b>St. James Village</b>					
21. I certify that (I) (this hospital) attended the deceased from <b>11/11/61</b> to <b>11/11/61</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>11/11/61</b> , and that death occurred <b>11/11/61</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Ralph Lyson</b>						22b. DATE SIGNED <b>11/13/61</b>					
22c. PHYSICIAN'S NAME (Type) <b>Ralph Lyson</b>						22d. ADDRESS <b>St. James Village</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>						23b. DATE THEREOF <b>Nov. 14-61</b>					
23c. NAME OF CEMETERY OR CREMATORY <b>Methodist Church Cemetery</b>						23d. LOCATION (City, town, county) (State) <b>Mayo, Maryland</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Albert L. Leaf</b>						25a. REC'D BY REGISTRAR <b>Williamport, Md</b>					
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>						25c. DATE <b>NOV 14 '61</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Be 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13158

13146

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Western Maryland State Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> d. STREET ADDRESS <u>18 Milton Ave</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>NEWTON MAURICE ECKARD</u>		<b>4. DATE OF DEATH</b> Month <u>Nov</u> Day <u>27</u> Year <u>1961</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Jan. 13 1872</u>
<b>9. AGE</b> (In years last birthday) <u>89</u>		<b>10. IF UNDER 1 YEAR</b> Months <u>2</u> Days <u>2</u>	
<b>11. IF UNDER 24 HRS.</b> Hours <u>2</u> Mins. <u>0</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Califf Lotte keeper</u>		<b>13b. KIND OF BUSINESS OR INDUSTRY</b> <u>Carroll Co. Md</u>	
<b>14. FATHER'S NAME</b> <u>Jose Eckard</u>		<b>15. MOTHER'S M.A.DEN NAME</b> <u>Arnie De Moss</u>	
<b>16. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>17. SOCIAL SECURITY NO.</b> <u>18 Milton Ave</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBULAR PNEUMONIA</u> (b) <u>CARCINOMA OF SOFT PALATE c METASTASIS</u> (c) <u>4 MONTHS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): <u>144X</u>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from <u>11-24-1961</u> to <u>11-27-1961</u>, that (I) <u>(see)</u> last saw the deceased alive on <u>11-27-1961</u>, and that death occurred at <u>9:45 AM</u>, from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Antonio U. Pella-groni</u>		<b>22b. DATE SIGNED</b> <u>11-27-1961</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>ANTONIO U. PALLACROSI</u>		<b>22d. ADDRESS</b> <u>1700 Pa AVE HAGERSTOWN MD.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>11/30/61</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Kridders Cemetery Rural Westminster, Md.</u>	<b>23d. LOCATION</b> (City, town or county) (State)
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. E. Meyer Jr., Westminster, Md.</u>		<b>25a. REG'D BY REGISTRAR</b>	<b>25b. REGISTRAR'S SIGNATURE</b> <u>William S. Kline</u>
<b>25c. DATE</b> <u>NOV 30 '61</u>		<b>25d. DATE</b>	



13159

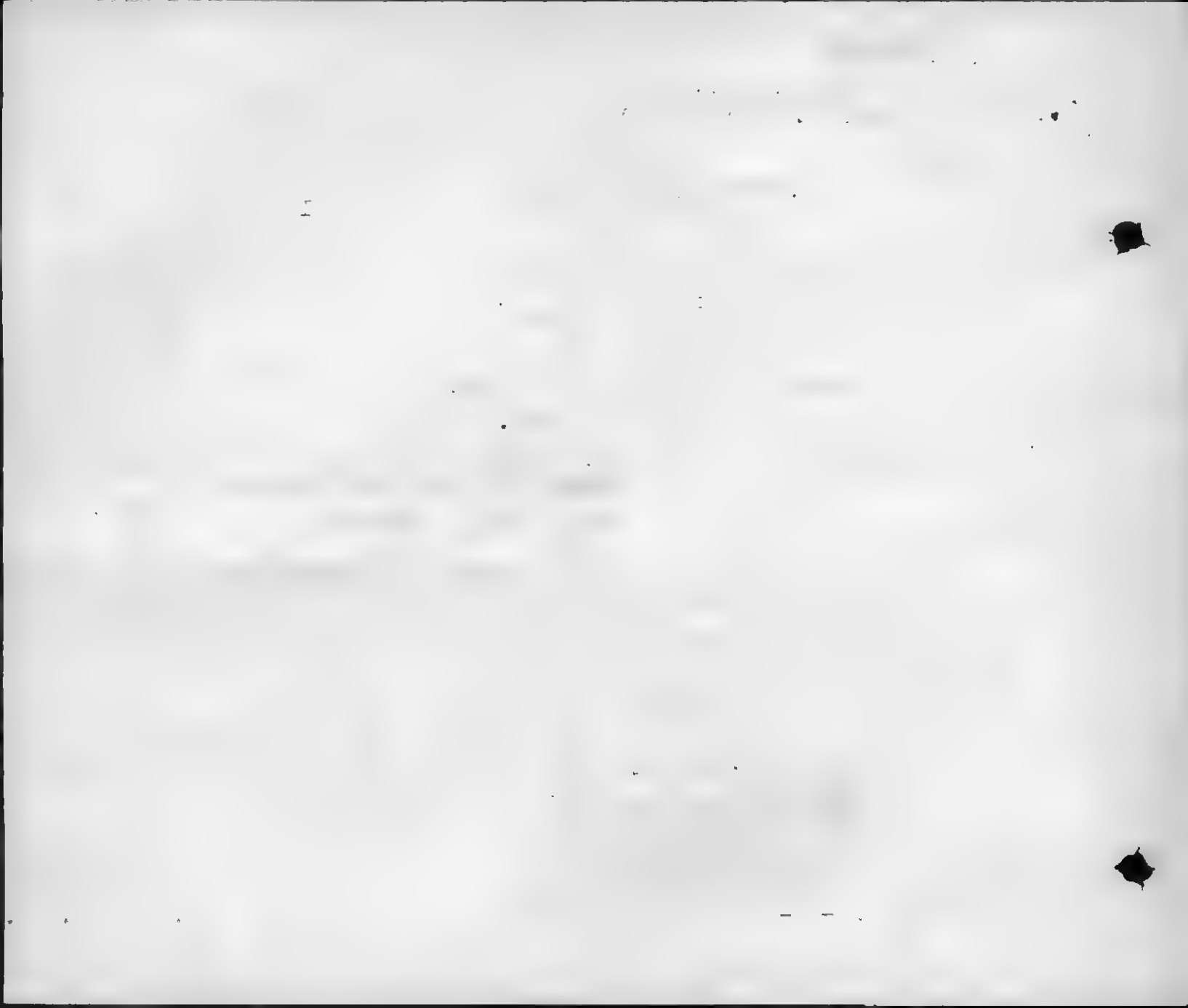
1  
**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

Hedgesville 1344 Berkeley

1 PLACE OF DEATH a. COUNTY <del>XXXXXXXXXX</del> Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Va b. COUNTY <del>XXXXX</del> Berkeley ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Hancock		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hedgesville W Va	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hancock Nursing Home Md Main St		d. STREET ADDRESS Route # 1	
3. NAME OF DECEASED (Type or print) <sup>First</sup> <sup>Middle</sup> <sup>Last</sup> Sara E Eichelberger		4. DATE OF DEATH 11 23 61 <sup>Month</sup> <sup>Day</sup> <sup>Year</sup>	
5 SEX Fem	6 COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1878 2 7
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY House wife	11. BIRTHPLACE (State or foreign country) Hedgesville W Va
12. CITIZEN OF WHAT COUNTRY? U. S. a		13. FATHER'S NAME Richard Wood Berkeley Co	
14. MOTHER'S MAIDEN NAME Tene Shriver Berkeley Co		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <sup>(If yes, give war or dates of service)</sup> no	
16. SOCIAL SECURITY NO. no		17. INFORMANT <sup>Address</sup> Mrs. Clayton M Canby Hedgesville W. Va	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <sup>142x</sup> DUE TO <i>Chronic Myocarditis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Cardiovascular</i> (c) <i>renal disease</i>		INTERVAL BETWEEN ONSET AND DEATH 6 mo	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 7/6 1961 to 11/23/61 that (I) (we) last saw the deceased alive on 11/23 1961, and that death occurred at M, from the causes and on the date stated above			
22a SIGNATURE <i>W. H. Shaffer M.D.</i>		22b. DATE SIGNED	
22c PHYSICIAN'S NAME (Type) Hancock Md		22a. ADDRESS Hancock Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-25-1961	
23c. NAME OF CEMETERY OR CREMATORY Tomahawk Cemetery		23d. LOCATION (City, town, or county) (State) Hedgesville Rt. # 2, W. Va.	
24 FUNERAL DIRECTOR'S SIGNATURE Howard K Brown Martinsburg W. Va		25a. REC'D BY REGISTRAR NOV 27 '61	
25b. REGISTRAR'S SIGNATURE W. S. Kraw			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13160

## CERTIFICATE OF DEATH

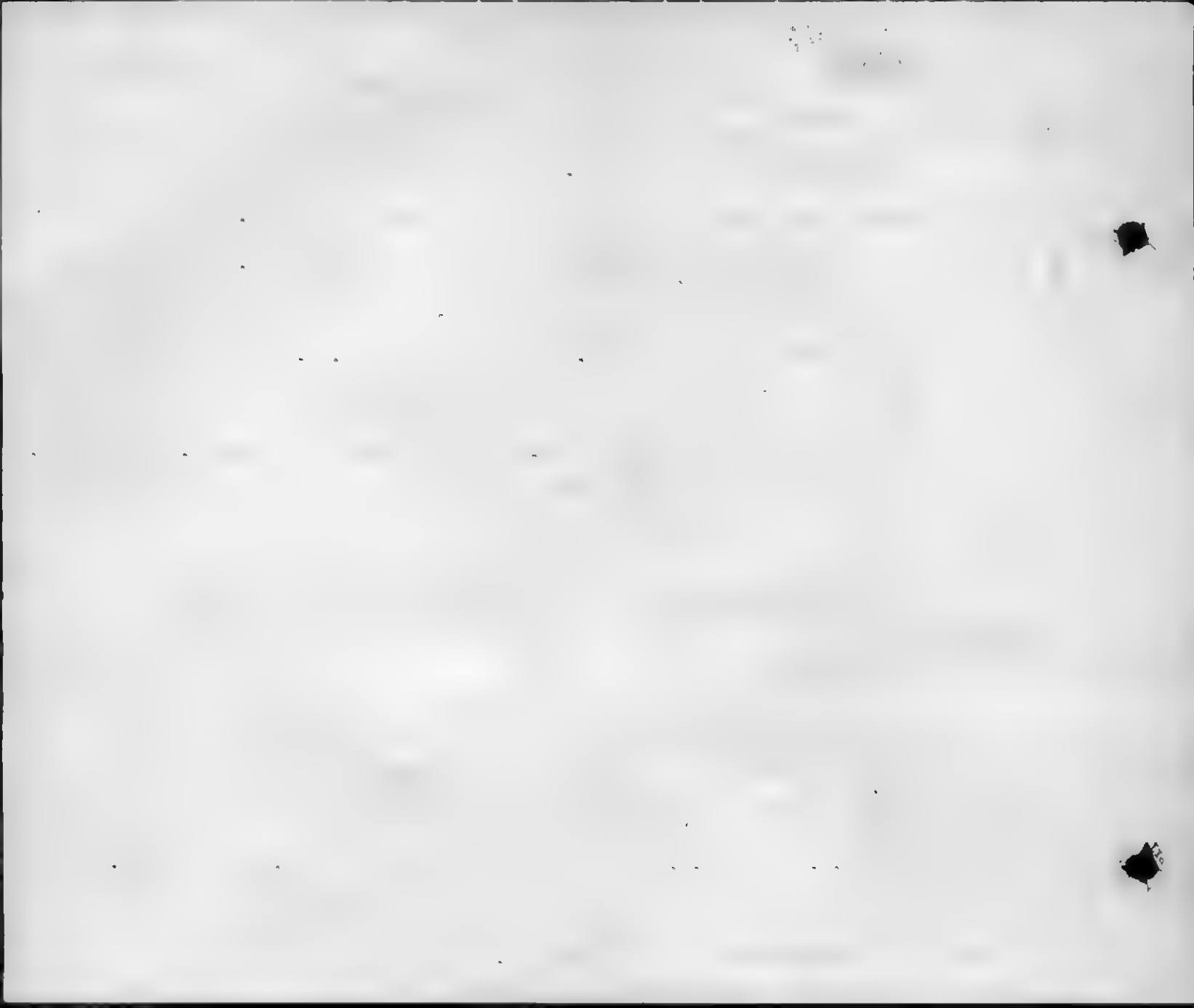
13148

1. PLACE OF DEATH a. COUNTY <u>Washington</u>		2. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before adm.s.sion) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>1127 Security Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Reno</u> Middle <u>Park</u> Last <u>Eyler</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>25</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1903</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hoist Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cement Mfg.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Park Eyler</u>		14. MOTHER'S MAIDEN NAME <u>Emma Susan Beard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-10-6853</u>	
17. INFORMANT <u>Mrs. Reno Eyler</u>		Address <u>1127 Security Rd. Hagerstown Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden heart failure with Coronary</u> DUE TO (b) <u>Arteriosclerosis of the heart</u> DUE TO (c) <u>Unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 12, 1955</u> to <u>Nov 25, 1961</u> that (I) (we) last saw the deceased alive on <u>Nov 25, 1961</u> and that death occurred <u>2:08 pm</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>L.L. Packer</u> M.D.		22b. DATE <u>11/27/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>L.L. Packer M.D.</u>		22d. ADDRESS <u>145 W. Washington St. Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/28/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Hagerstown Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Horst</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		DATE <u>NOV 29 '61</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

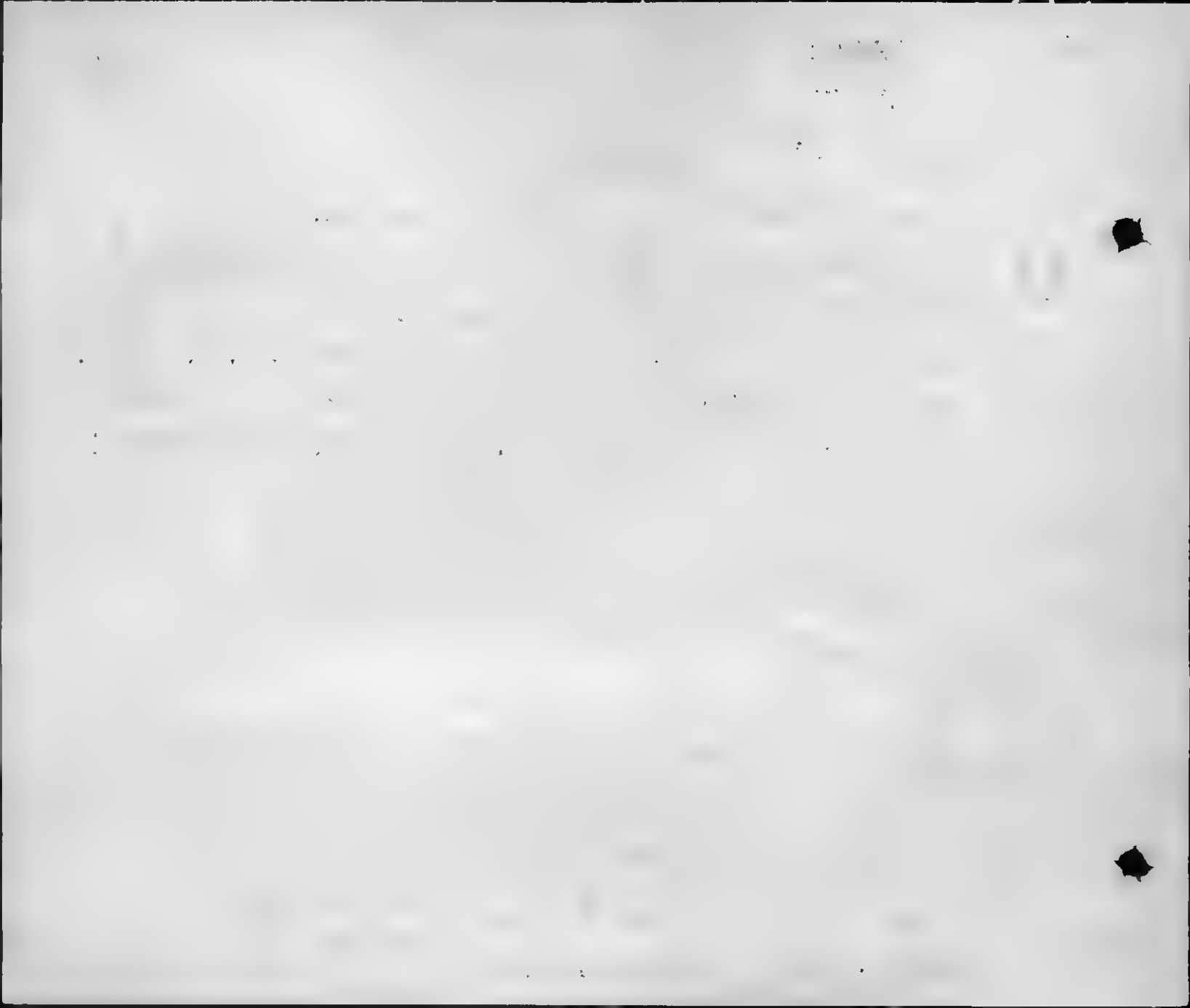
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13161

## CERTIFICATE OF DEATH

13149

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Boonesboro</u> c. LENGTH OF STAY IN b. <u>8 Months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Reeder Nursing Home</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>609 Salem Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>MARY ELLEN FEISER</u> First Middle Last <b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>October 15, 1879</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (In years, test birthday) <u>82</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.		<b>4. DATE OF DEATH</b> <u>November 28</u> 19 <u>61</u> Month Day Year <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Williamsport, Wash. Co. Md.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA.</u>	
<b>13. FATHER'S NAME</b> <u>JACOB H. PITTSNOGLE</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war and dates of service) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>4200</u> <b>17. INFORMANT</b> <u>Mrs. Merle Feiser</u> Address <u>Hagerstown, Maryland, Lincolnshire Dr.</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>ANNIE (GOSSARD) PITTSNOGLE</u> <b>18. CAUSE OF DEATH</b> [Enter only one cause for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema acute</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>4200</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19 <u>61</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>April, 1961</u> to <u>Nov 28, 1961</u> , that (I) (we) last saw the deceased alive on <u>11-28-1961</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above. <b>22a. SIGNATURE</b> <u>Hagerstown</u> M.D. <b>22b. DATE SIGNED</b> <u>11-28-1961</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>JOSEPH SECONDARI</u> <b>22d. ADDRESS</b> <u>BOONESBORO Md</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>12/1/61</u> <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Andrew K. Coffman</u> <b>ADDRESS</b> <u>Hagerstown, Maryland</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rest Haven Cemetery</u> <b>23d. LOCATION (City, town or county)</b> <u>Hagerstown, Maryland</u> (State) <b>25a. REC'D BY REGISTRAR</b> <u>DEC 4 '61</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hanks</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the attending physician and coroner be filled in by the funeral director. After this certificate has been signed by the attending physician and coroner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13162

CERTIFICATE OF DEATH

1515

1. PLACE OF DEATH  
a. COUNTY

WASHINGTON

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN 1b

HAGERSTOWN

24 HOURS

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

WASH. CO. HOSPITAL

3. NAME OF DECEASED  
(Type or print)

EVA MARY FITZGERALD

5. SEX

FEMALE

WHITE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

NOVEMBER-12-1898

9. AGE (in years last birthday)

62 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY

OWN HOME

11. BIRTHPLACE (County & State, or foreign country)

RIVERSIDE VA.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JORDAN

SHOEMAKER

14. MOTHER'S MAIDEN NAME

ETTA

SHOEMAKER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

NO.

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

EUSTACE B. FITZGERALD

Address

KEEDYSVILLE MD. 21.1

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Coronary Hemorrhage

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

DUE TO

DUE TO

Hypertensive Heart Disease

INTERVAL BETWEEN ONSET AND DEATH  
24 hours

7 cm

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY  
Month, Day, Year  
Hour a.m.  
p.m.

20d. INJURY OCCURRED  
While at work  
Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 10-12-1961, to 11-5-1961, that (I) (we) last saw the deceased alive on 11-5-1961, and that death occurred at 6 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Heretian

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED  
11-5-1961

22c. PHYSICIAN'S NAME (Type)

JOSEPH SECONDARI

22d. ADDRESS

BOONSBORO MD

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

NOV. 8, 1961

23c. NAME OF CEMETERY OR CREMATORY

MT. CARMEL CEMETERY

23d. LOCATION (City, town or county)

STEELE TAVEN VA.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

John A. Baer

ADDRESS

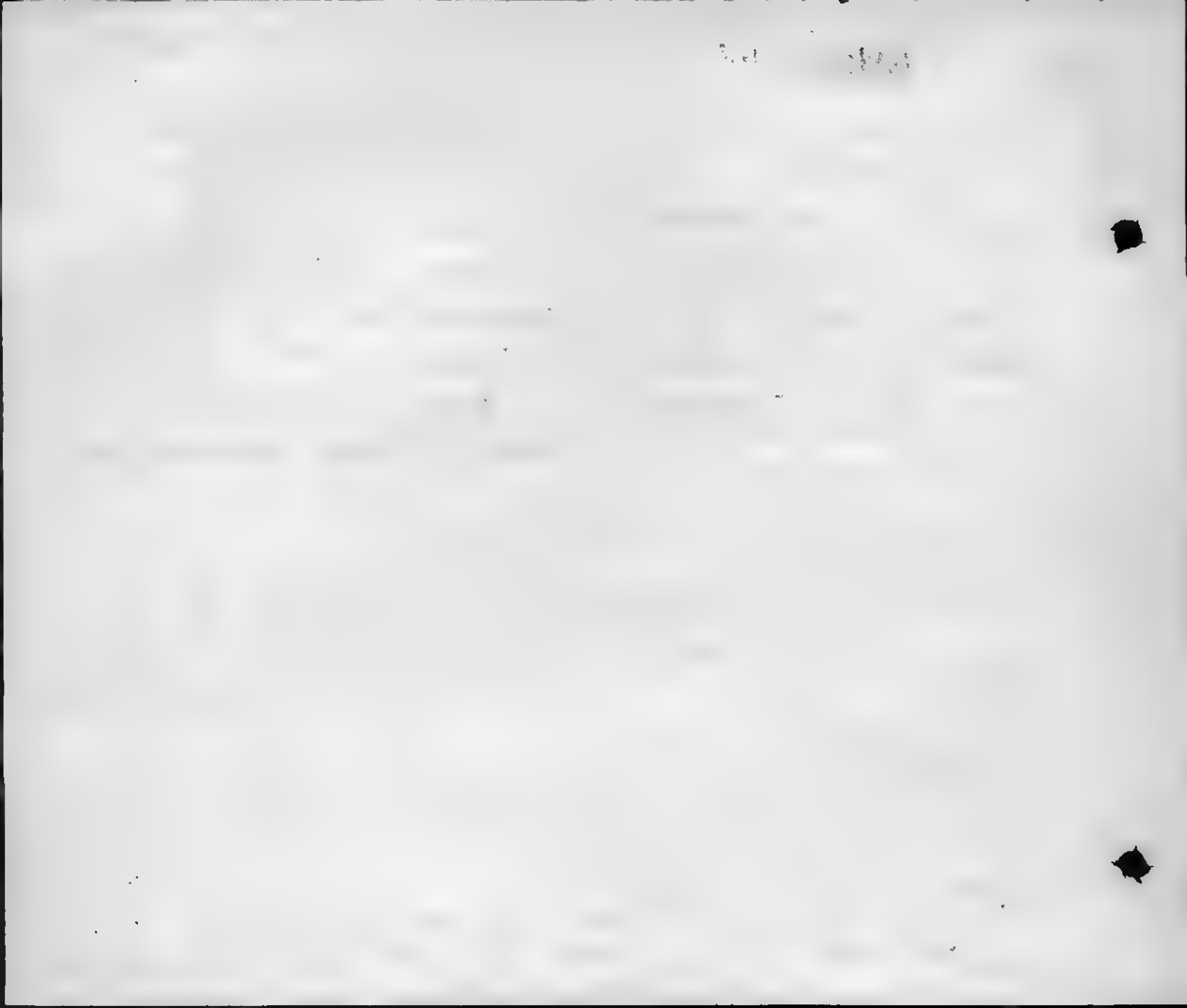
BOONSBORO MD

25a. REC'D BY REGISTRAR

DATE NOV 8 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13163

## CERTIFICATE OF DEATH

Items 1 & 2 from G300 11/10/61 iwk

13151

1. PLACE OF DEATH a. COUNTY <u>Machington</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gettysburg, Md. Park View</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Union Bridge</u>			
c. LENGTH OF STAY IN 1b <u>7 yr</u>				d. STREET ADDRESS <u>U.S. #2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harvey-Kesedy Memorial</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Carne</u> Middle <u>Louise</u> Last <u>Barnes</u>				4. DATE OF DEATH Month <u>11</u> Day <u>11</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-20-1877</u>	
9. AGE (In years last birthday) <u>84</u> yrs		IF UNDER 1 YEAR Months <u>84</u> Days <u>84</u>		IF UNDER 24 HRS. Hours <u>84</u> Min. <u>84</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home work</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home work</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Gaspar C. Barnes</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Gou Barnes</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 17. INFORMANT <u>Chen Barnes, Westminster Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiac vascular disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>18 months</u> (e), stating the underlying cause last. (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 2</u> 1961, to <u>Nov 10</u> 1961, that (I) (we) last saw the deceased alive on <u>Nov 10</u> 1961, and that death occurred <u>11:55 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>G. W. Whelan</u>				22b. DATE SIGNED <u>Nov. 11, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>G. W. Whelan</u>				22d. ADDRESS <u>Boonville, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>11-13-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Park Creek</u>		23d. LOCATION (City, town or county) (State) <u>Uniontown Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond T. Wright</u>				25a. REC'D BY REGISTRAR <u>Nov 14 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles S. Finner</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13164

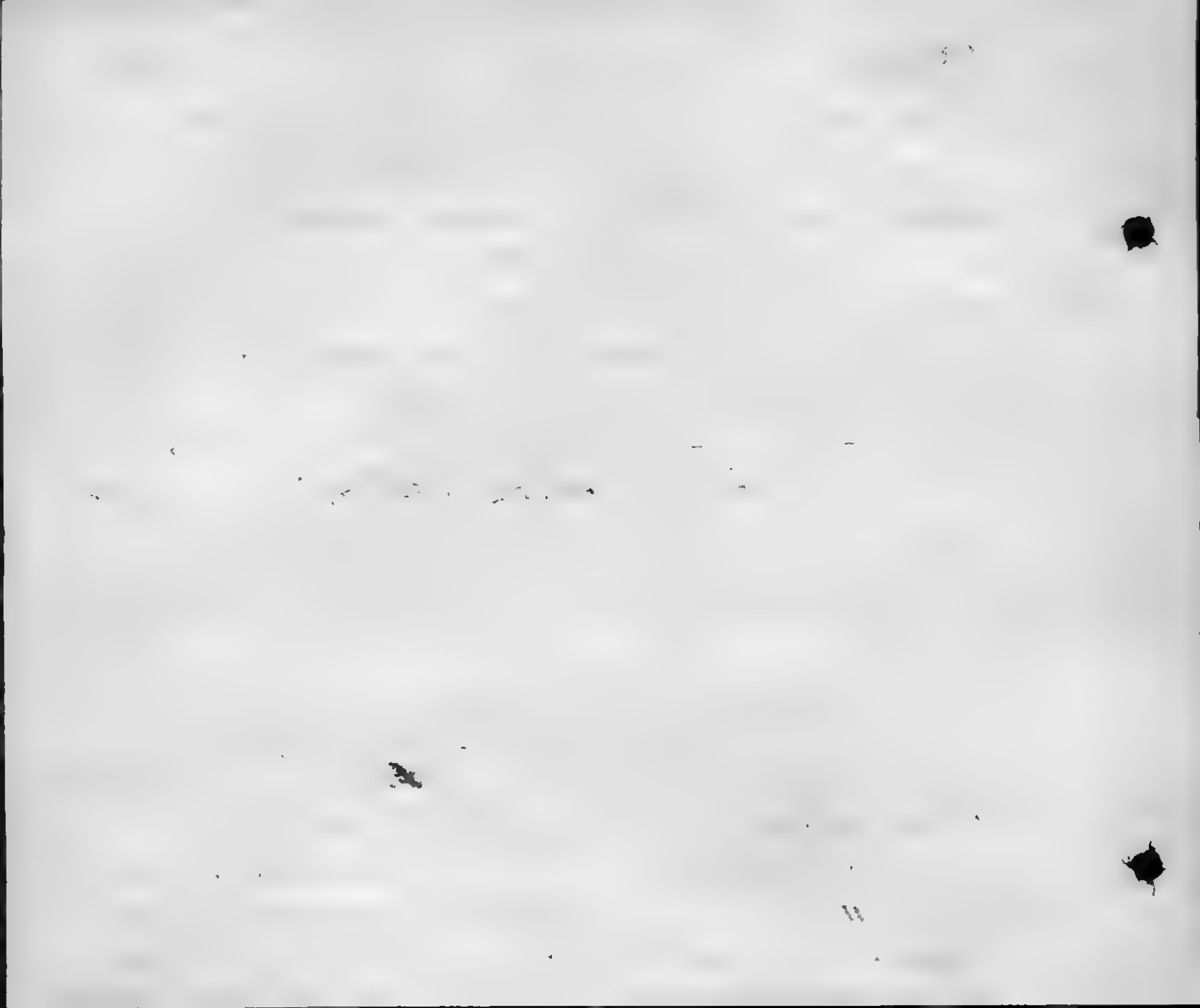
## CERTIFICATE OF DEATH

13152

Item 2 Film G302 12/7/61 iwk

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>6 Hrs</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		e. STREET ADDRESS <b>High Street</b>		f. NATURE OF DEATH <b>Natural / Nursing Home</b>		4. DATE OF DEATH <b>November 27 1961</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BESSIE VIRGINIA GREEN</b>		8. DATE OF BIRTH <b>April 27 1879</b>		9. AGE (In years last birthday) <b>82 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Boonsboro Wash Co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Charles Souffins</b>	
14. MOTHER'S MAIDEN NAME <b>No Record</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>214-09-9168</b>		17. INFORMANT <b>Catherine Green</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ac. Myo CAR DIA L IN FRACTION</b> DUE TO (b) <b>Hagerstown Md.</b> DUE TO (c) <b>Immediate</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Williamsport, Wash. Co. Maryland</b>		20g. (County) <b>Washington</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>11/27/61</b> to <b>11/27/61</b> , 19...., that (I) (we) last saw the deceased alive on <b>11/27/61</b> , 19...., and that death occurred <b>11/27/61</b> M., from the causes and on the date stated above.		22a. SIGNATURE <b>Dr. Ralph Young</b>		22b. DATE SIGNED <b>11/27/61</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. Ralph Young</b>		22d. ADDRESS <b>Williamsport, Wash. Co. Maryland</b>		22e. (State) <b>Md.</b>		22f. (City or town) <b>Boonsboro</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/30/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Boonsboro Cemetery</b>		23d. LOCATION (City, town or county) <b>Boonsboro Wash Co Md</b>		23e. (State) <b>Md.</b>		23f. (City or town) <b>Boonsboro</b>		23g. (County) <b>Washington</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		24b. DATE <b>DEC 4 '61</b>		24c. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		24d. (City or town) <b>Hagerstown Md.</b>		24e. (State) <b>Md.</b>		24f. (City or town) <b>Hagerstown</b>		24g. (County) <b>Washington</b>	

VR A15 (4)  
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law requires that the death certificate be retained by the hospital or attending physician. The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**1**

**M**

**I**

**13163**

**13152**

**Item 9 Film G301 11/24/61 iwk**

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

**1. PLACE OF DEATH**  
 a. COUNTY **Washington**  
 b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Hagerstown**  
 c. LENGTH OF STAY IN b. **4 Yrs**  
 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Garlock Nursing Home**

**2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)**  
 a. STATE **Maryland**  
 b. COUNTY **Washington**  
 c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Hagerstown**  
 d. STREET ADDRESS **1023 View St**  
 e. RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED**  
 (Type or print)  
**JACK (NMN) GREENWALD**

**5. SEX** **Male**  
**6. COLOR OR RACE** **White**  
**7. MARRIED** ☒ **NEVER MARRIED** ☐  
**8. DATE OF BIRTH** **Nov 21 1898**  
**9. AGE (In years)** **62/63**  
**10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)** **Owner-Operator News Agency**  
**11. BIRTHPLACE (County & State, or foreign country)** **Pa.**  
**12. CITIZEN OF WHAT COUNTRY?** **USA**

**13. FATHER'S NAME** **David Greenwald**  
**14. MOTHER'S MAIDEN NAME** **Anna Friedman**

**15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)** **Yes**  
**16. SOCIAL SECURITY NO.** **W.W.#1 193-28-5176**  
**17. INFORMANT** **Melvin Greenwald**  
**Address** **919 Rolling Road Hagerstown Md.**

**18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)**  
 PART I. DEATH WAS CAUSED BY:  
 IMMEDIATE CAUSE (a) **Cerebral Thrombosis**  
 DUE TO  
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) **Arteriosclerosis - Generalized**  
 DUE TO (c) **Diabetes Mellitus**

**PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)**

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)** ☐  
**20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)**

**20c. TIME OF INJURY** Month, Day, Year **19**  
 Hour a.m. **19**  
 p.m. **19**  
**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐  
**20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)**  
**20f. (City or town)** **Hagerstown**  
**(County)** **Washington**  
**(State)** **Md.**

**21. I certify that (I) (this hospital) attended the deceased from Feb. 1953 to Nov. 19, 1961, that (I) (we) last saw the deceased alive on Nov. 19, 1961, and that death occurred at 3:30 P.M. from the causes and on the date stated above.**

**22a. SIGNATURE** **David A. Hoffman**  
**22b. DATE SIGNED** **11/20/61**  
**22c. PHYSICIAN'S NAME (Type)** **David A. Hoffman**  
**22d. ADDRESS** **214 N. Potomac St. Hagerstown, Md.**

**23a. BURIAL, CREMATION, REMOVAL (Specify)** **Burial**  
**23b. DATE THEREOF** **11/21/61**  
**23c. NAME OF CEMETERY OR CREMATORY** **Bethel Abraham Cemetery - Hagerstown, Maryland**  
**23d. LOCATION (City, town or county)** **Hagerstown**  
**(State)** **Md.**

**24. FUNERAL DIRECTOR'S SIGNATURE** **Andrew K. Coffman**  
**Address** **Hagerstown Md.**  
**25a. REC'D BY REGISTRAR** **NOV 21 '61**  
**25b. REGISTRAR'S SIGNATURE** **Arthur S. Kraus**

**VR A15 (4)**  
**15M 9/60**



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**13166**

Reg. Dist. No. **13154**

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution, residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>6 + 4mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u> 72			
a. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Garlock Memorial Conv. Hospital</u>				d. STREET ADDRESS <u>17 S. Carlisle St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CLARA</u> First <u>E.</u> Middle <u>HADE</u> Last				4. DATE OF DEATH <u>Nov</u> Month <u>27</u> Day <u>1961</u> Year			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/1/1868</u>		9. AGE (In years last birthday) <u>93</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob W. Heatherman</u>				14. MOTHER'S MAIDEN NAME <u>Emeline Gross</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Regen. L. Furry</u> Address <u>412 W. Potomac Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Arteriosclerosis and Arterio-</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Sclerotic Heart Disease with</u> DUE TO <u>Senility</u> (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Intertrochanteric Fracture of Right hip (Femur)</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>(Crawled over foot of bed and fell to floor)</u>					
20c. TIME OF INJURY Hour <u>7:20</u> a. m. <u>  </u> p. m. Month, Day, Year <u>6/14/1961</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Garlock Hospital</u>		20f. (City or town) <u>Hagerstown</u>	(County) <u>Wash</u>	(State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Edward W. Ditto III</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11/25/61</u>	
EXAMINER'S NAME (Type) <u>Edward W. Ditto III, M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u>		22b. DATE THEREOF <u>11/30/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Greencastle, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.C. Mennich</u>				ADDRESS <u>Greencastle, Pa.</u>		24a. REC'D BY REGISTRAR <u>NOV 30 '61</u> DATE	
				24b. REGISTRAR'S SIGNATURE <u>C. S. Furry</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

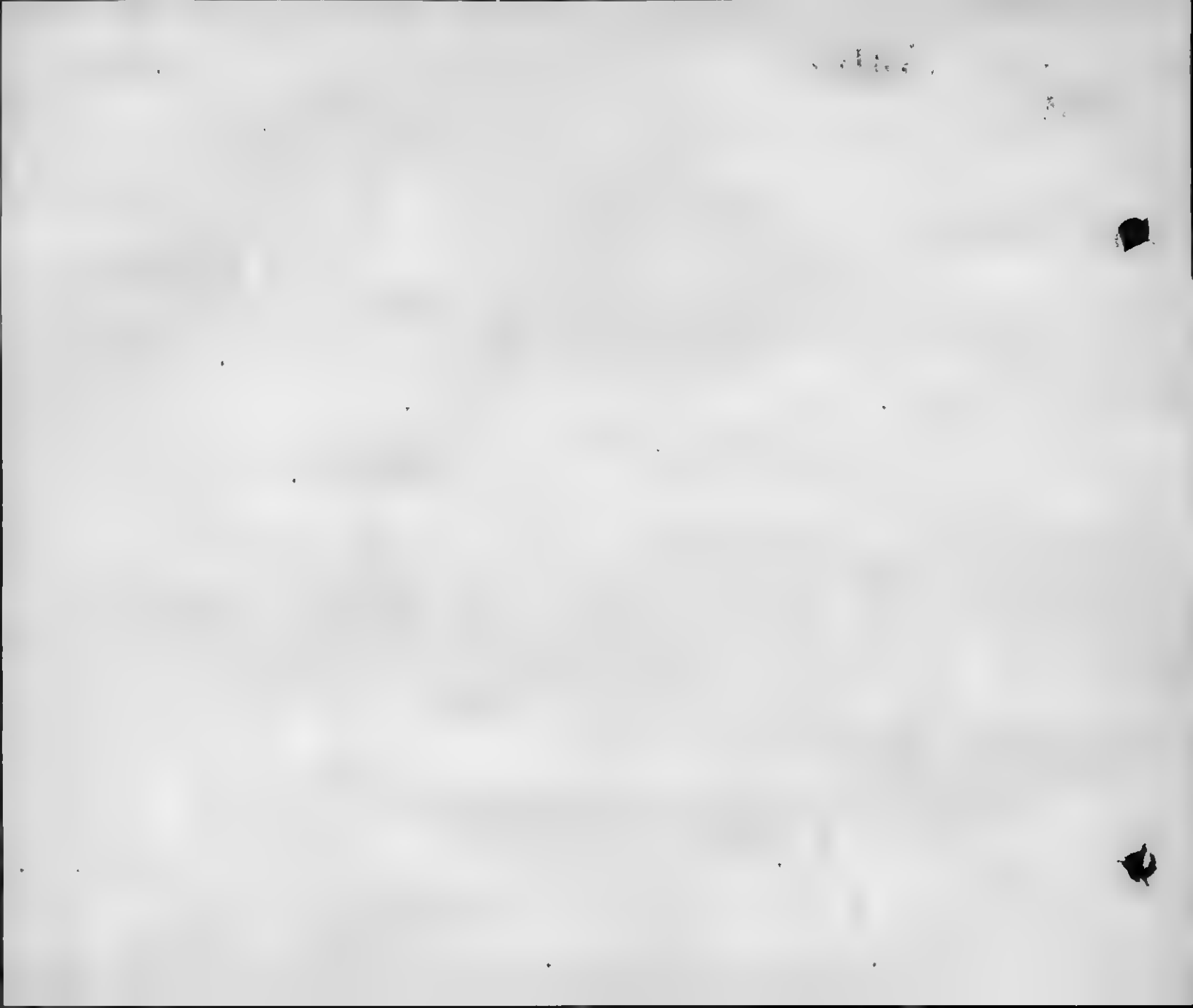
## CERTIFICATE OF DEATH

13167

13155

1. PLACE OF DEATH		2. USUAL RESIDENCE	
a. COUNTY	b. CITY OR TOWN	a. STATE	b. COUNTY
Washington	Hagerstown	Maryland	Washington
c. LENGTH OF STAY IN PL.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
12 Hrs		Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
Wash County Hospital		917 So Potomac St	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
MARY CATHERINE HEIST		Nov 23 1961	
5. SEX		6. COLOR OR RACE	
Female		White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		July 11 1887	
9. AGE (In years last birthday)		10. AGE (In years last birthday)	
74 yrs.		74 yrs.	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Hagerstown Wash Co Md.		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
David S. Fisher		Ann J. Alexander	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
No		214-09-7734	
17. INFORMANT		18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c).)	
Julian Saunders		Cardiac Standstill	
917 So Potomac St		Posterior Myocardial Infarction	
Hagerstown Md.		Arteriosclerotic Heart Disease	
19. WAS AUTOPSY PERFORMED?		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Thrombosis of Middle Cerebral Artery	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
22a. TIME OF INJURY Month, Day, Year		22b. INJURY OCCURRED	
Hour a.m. p.m.		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
19			
23a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		23b. (City or town)	
		(County) (State)	
24. I certify that (1) <del>THIS DECEASED</del> attended the deceased from....., 19....., to....., 19....., that (1) <del>(we)</del> last saw the deceased alive on....., 11/21....., 1961, and that death occurred at.....P.....M, from the causes and on the date stated above		25. DATE SIGNED	
22c. SIGNATURE		22d. ADDRESS	
John C. Stauffer, M.D.		145 S. Prospect St. Hagerstown, Md	
23c. BURIAL, CREMATION, REMOVAL (Specify)		23d. DATE THEREOF	
Burial		11/24/61	
23e. NAME OF CEMETERY OR CREMATORY		23f. LOCATION (City, town or county)	
Rose Hill Cemetery		Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE		25. REC'D BY REGISTRAR	
Andrew K. Coffman Hagerstown Md.		NOV 24 '61	
26. REGISTRAR'S SIGNATURE		27. REGISTRAR'S SIGNATURE	
Arthur S. Kline			

VR A15 (4)  
15M 9/60



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

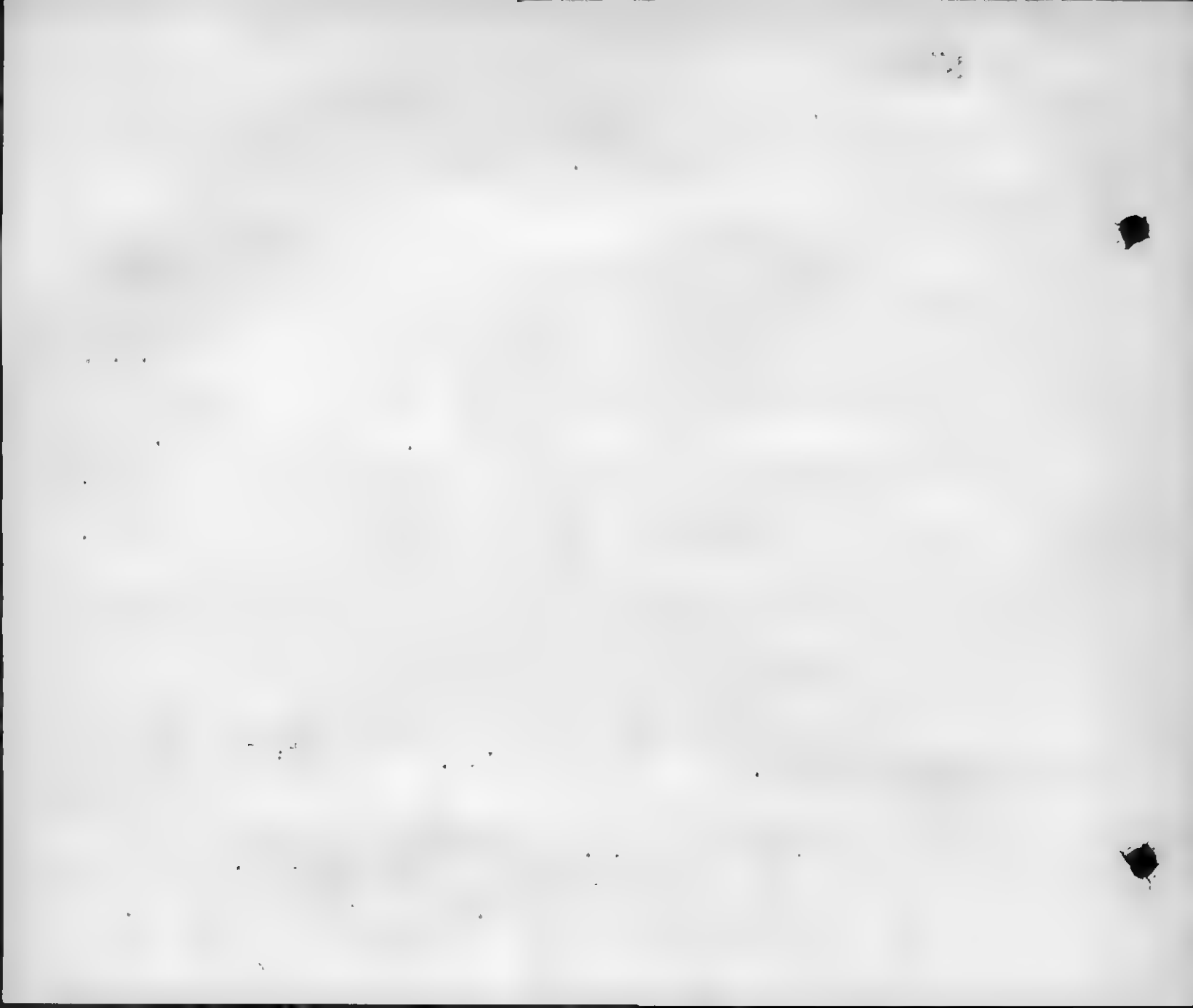
## CERTIFICATE OF DEATH

**13168**

**13156**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>10 YRS.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>901 WOODLAND WAY</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>901 WOODLAND WAY</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>LAUGHTY</b> <b>DUVALL</b> <b>HOLLYDAY</b>				<b>4. DATE OF DEATH</b> <b>November 23, 1961</b> <b>NOVEMBER 23 19 61</b>			
<b>5. SEX</b> <b>FEMALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>12/13/1882</b>		<b>9. AGE</b> (In years last birthday) <b>78 yrs.</b> IF UNDER 1 YEAR: Months <b>23</b> Days <b>23</b> Hours <b>61</b> Min.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>MARYLAND</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>HOME</b>			
<b>13. FATHER'S NAME</b> <b>WILLIAM D. MIDDLEKAUFF</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>ANNA PIPER</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>		<b>17. INFORMANT</b> <b>MR. JOHN S. HOLLYDAY</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO (b) <b>Hypertensive vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) _____							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. _____ 19____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____			
<b>21. I certify that</b> (I) (this hospital) <b>Jan. 5, 1951</b> <b>to Oct. 30, 1961</b> <b>that (I) (we) last saw the deceased alive on</b> <b>Oct. 20, 1961</b> <b>at</b> <b>10 p.m.</b> <b>to 12 midnight</b> <b>approximate</b>							
<b>22a. SIGNATURE</b> <b>B. B. Kneisley</b>							
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>B. B. Kneisley, M.D.</b>		<b>22d. ADDRESS</b> <b>148 West Washington Street</b> <b>Hagerstown, Md.</b>		<b>22b. DATE SIGNED</b> <b>11/27/61</b>			
<b>23a. BURIAL CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>11/27/61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>FUNKSTOWN CEM.</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W. J. Normant</b>		<b>25a. REC'D BY REGISTRAR</b> <b>NOV 28 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>William S. Kenna</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13169

13157

### 1. PLACE OF DEATH

a. COUNTY

ALLEGANY WASHINGTON

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

HAGERSTOWN

c. LENGTH OF STAY IN

3 WEEKS

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

WESTERN MARYLAND STATE HOSPITAL

### 3. NAME OF

(Type or print)

Campbell Arthur Hook

### 5. SEX

MALE

### 6. COLOR OR RACE

WHITE

### 7. MARRIED

NEVER MARRIED

### 8. DATE OF BIRTH

April 14, 1889

### 9. AGE (In years last birthday)

72 yrs.

### 10. IF UNDER 1 YEAR

Months Days

### 11. IF UNDER 24 HRS.

Hours Min.

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LABORER

10b. KIND OF BUSINESS OR INDUSTRY

RAILROAD

11. BIRTHPLACE (Country & State, or foreign country)

W. VA.

12. CITIZEN OF WHAT COUNTRY?

USA

### 13. FATHER'S NAME

J. SAMUEL HOOK

### 14. MOTHER'S MAIDEN NAME

ANNA McCARTY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

NO

16. SOCIAL SECURITY NO.

A 576361

### 17. INFORMANT

RHODA HOOK

CUMBERLAND, MD.

### 18. CAUSE OF DEATH (Enter only one cause for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)

Lobular pneumonia  
Carcinoma of face, left

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Nov. 8, 1961, to Nov. 28, 1961, that (I) (two) last saw the deceased alive on Nov. 28, 1961, and that death occurred at 5:45 PM, from the causes and on the date stated above.

### 22a. SIGNATURE

Young E. Chun  
YOUNG E. CHUN

### ATTENDING PHYS.

### MED. DIRECTOR

### STAFF PHYS.

22d. ADDRESS

Western Maryland State Hospital  
Hagerstown, Maryland

### 22b. DATE SIGNED

Nov. 28, 1961

### 23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

### 23b. DATE THEREOF

NOV. 30, 1961

### 23c. NAME OF CEMETERY OR CREMATORY

HILLCREST BURIAL PARK

### 23d. LOCATION (City, town or county)

CUMBERLAND, MD.

### 24. FUNERAL DIRECTOR'S SIGNATURE

BYRON KIGHT

CUMBERLAND, MD.

### 25a. REC'D BY REGISTRAR

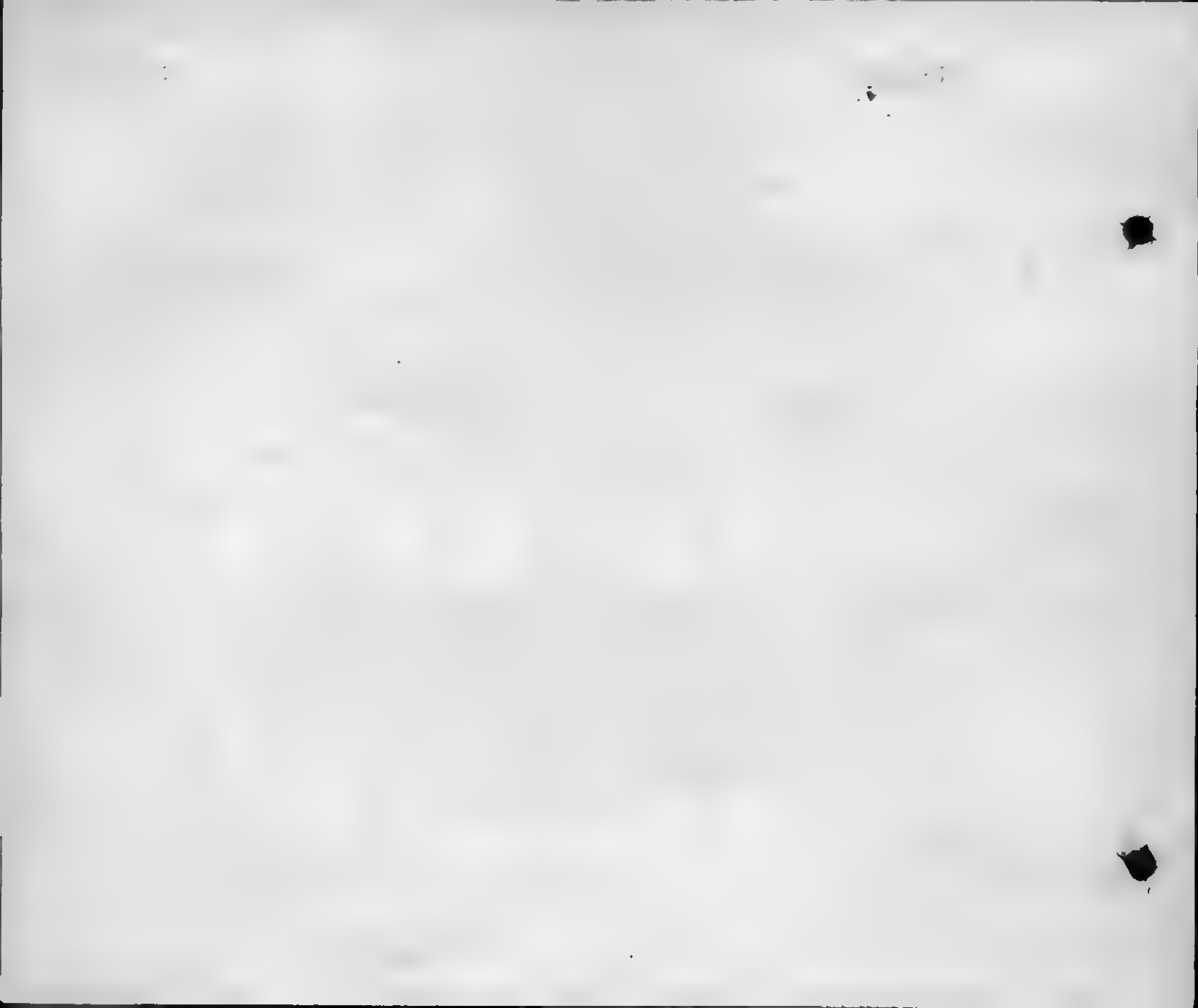
DATE NOV 30 '61

### 25b. REGISTRAR'S SIGNATURE

Robert S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

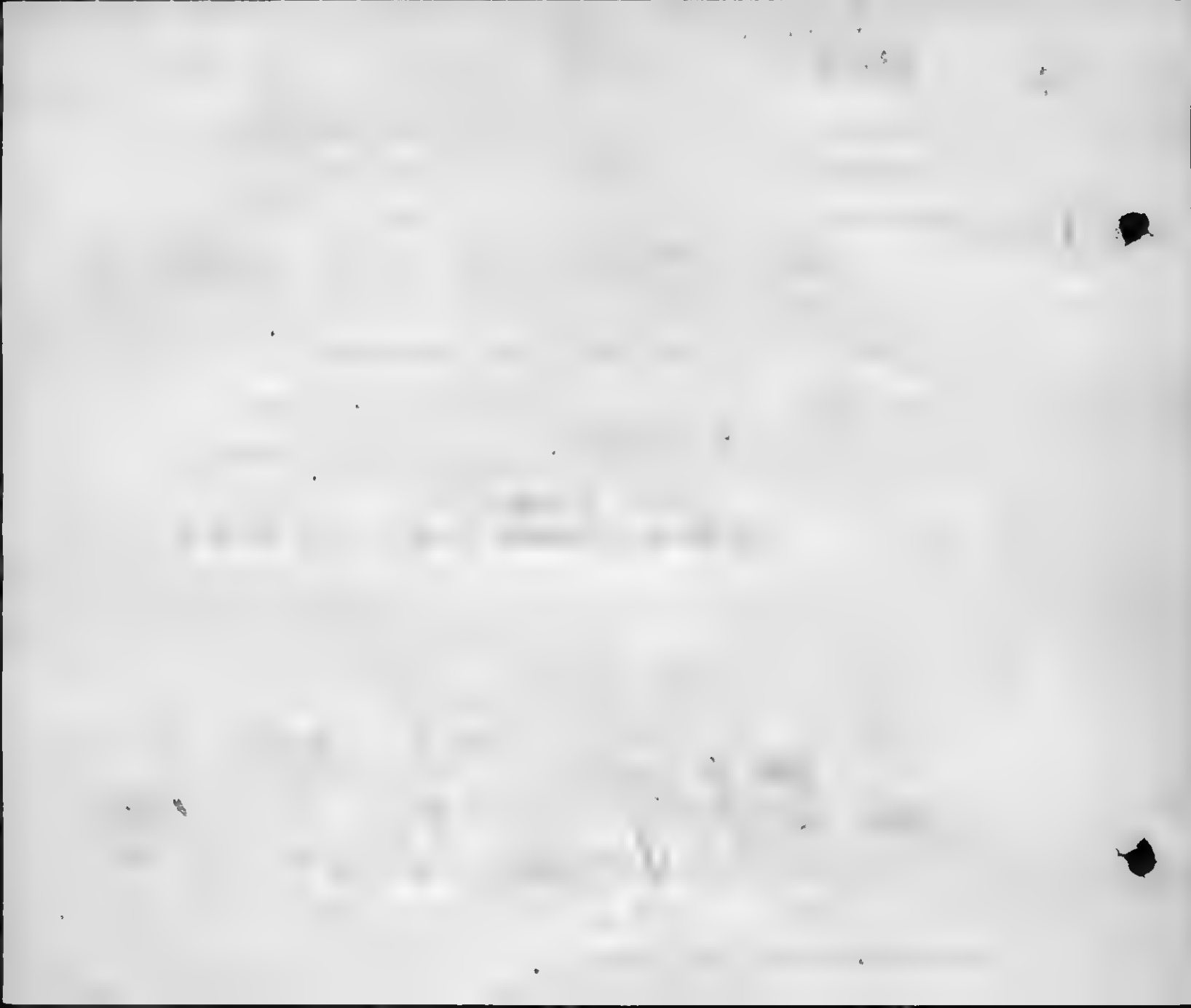
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13170

13158

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg</u> c. LENGTH OF STAY IN b. <u>5 Yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>225 Chaplin St</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg</u> d. STREET ADDRESS <u>225 Chaplin St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>SUSAN CATHERINE HUYETT</u>		<b>4. DATE OF DEATH</b> Month <u>Nov</u> Day <u>1</u> Year <u>1961</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Aug 6 1883</u>
<b>9. AGE</b> (In years last birthday) <u>78</u> yrs.		<b>10. AGE</b> (In years last birthday) <u>78</u> yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Pa.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Calvin Miner</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Katherine L. Harbaugh</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>376-18-9893F</u>	
<b>17. INFORMANT</b> <u>Anwilda Scott</u>		<b>18. CAUSE OF DEATH</b> (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis Cordis-Vasculardis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 yrs</u> DUE TO (c) <u>2 yrs</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. TIME OF INJURY</b> Month, Day, Year <u>19</u>	
<b>20c. TIME OF INJURY</b> Hour a.m. <u>19</u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from, 1959, 19... to 1961, that (I) (we) last saw the deceased alive on 8/31/1961, and that death occurred at... M, from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Walter H. Shealy</u>		<b>22b. DATE SIGNED</b> <u>11/3/61</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>WALTER H. SHEALY MD.</u>		<b>22d. ADDRESS</b> <u>Sharpsburg, Md</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>11/4/61</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rose Hill Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Hagerstown Wash Co Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Andrew K. Coffman</u>		<b>25a. REC'D BY REGISTRAR</b> <u>NOV 6 '61</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kraus</u>		<b>25c. DATE</b> <u>NOV 6 '61</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13171

11518

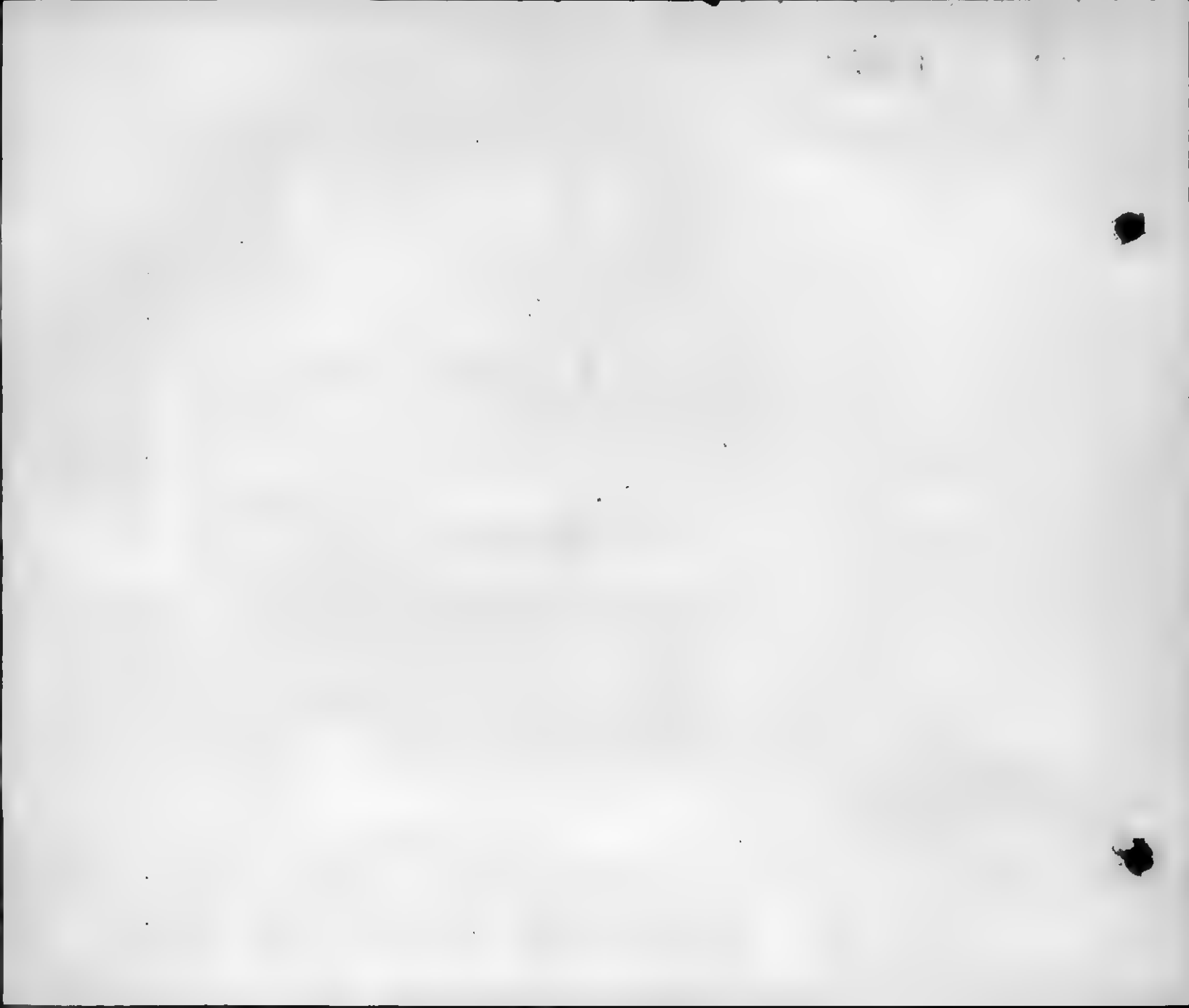
<b>1. PLACE OF DEATH</b> a. COUNTY <u>WASHINGTON</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO RURAL</u> c. LENGTH OF STAY IN 1b <u>43 YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BOONSBORO MD. R. 2</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> <b>MARYLAND</b> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO RURAL</u> d. STREET ADDRESS <u>BOONSBORO MD. R. 2</u>		<input type="checkbox"/> IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) <u>ANNA VIRGINIA ITNYRE</u>		<b>4. DATE OF DEATH</b> <u>NOVEMBER 30 1961</u>		Day Year
<b>5. SEX</b> <u>FEMALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>APRIL 11-1880</u>	
<b>9a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		<b>9b. KIND OF BUSINESS OR INDUSTRY</b> <u>OWN HOME</u>		<b>9. AGE</b> (In years last birthday) <u>81</u> yrs.
<b>10a. BIRTHPLACE</b> (County & State, or foreign country) <u>MT. LENA WASH. CO. MD.</u>		<b>10b. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>11. IF UNDER 1 YEAR</b> Months <u>7</u> Days <u>19</u>
<b>13. FATHER'S NAME</b> <u>JACOB ELI WEDDIE</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>EMMA JANE HARRISON</u>		<b>12. IF UNDER 24 HRS.</b> Hours <u>10</u> Min. <u>00</u>
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT</b> <u>THELMA V. ITNYRE BOONSBORO MD. R. 2</u>
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Heart Disease with myocardial infarct</u> <u>1720.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>factor</u> (c), stating the underlying cause last. DUE TO				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Bilateral thrombosis of popliteal arteries</u>				
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) <u>W</u>				
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Jan 1919</u> <b>to</b> <u>30 Nov 1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>27 Nov 1961</u> <b>and that death occurred</b> <u>215 P</u> <b>from the causes and on the date stated above.</b>				
<b>22a. SIGNATURE</b> <u>J. J. Lusby</u>		<b>22b. DATE SIGNED</b> <u>11/21/61</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>J. J. Lusby</u>
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>DEC. 3, 1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>BOONSBORO CEMETERY</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John A. Ball</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DATE DEC 13 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>C. J. S. Harris</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. Pages 1 and 2 should be filled in by the funeral director. After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
13172  
13159  
13159  
13159

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BEANSBORO</b> c. LENGTH OF STAY IN IL <b>3 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>REEDER NURSING HOME</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>MAPLEVILLE ROAD RURAL</b> d. STREET ADDRESS <b>BOONSBORO MD. R. 2</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF (Type or print) <b>J</b>		4. DATE OF DEATH <b>NOVEMBER 20 1961</b>		5. SEX <b>MALE</b>	
6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>		8. DATE OF BIRTH <b>JANUARY 16 1877</b>	
9. AGE (in years last birthday) <b>84 yrs.</b>		10. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>		11. BIRTHPLACE (County & State, or foreign country) <b>NEAR BOONSBORO WASH. CO. MD. U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JACOB E. ITNYRE</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE WILKINS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-36-2515</b>		17. INFORMANT <b>MISS THELMA V. ITNYRE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Heart Disease with myocardial failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>7222</b> (c) <b>myocardial failure</b> DUE TO cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1955</b> to <b>1961</b> , that (I) (also) last saw the deceased alive on <b>20 Nov 1961</b> , and that death occurred at <b>10 P.M.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>F. F. Lusby</b>		22b. DATE SIGNED <b>NOV 22 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>F. F. Lusby</b>		22d. ADDRESS <b>230 N Potomac St Hagerstown Md</b>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>NOV. 22 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY</b>	
23d. LOCATION (City, town or county) <b>BOONSBORO WASH. CO. MD.</b>		23e. (State) <b>MD.</b>		23f. (State) <b>MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Rust</b>		24a. ADDRESS <b>BOONSBORO MD.</b>		25a. REC'D BY REGISTRAR <b>NOV 22 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>		25c. (State) <b>MD.</b>		25d. (State) <b>MD.</b>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. [redacted] may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS 115 (4)  
15M 9/60

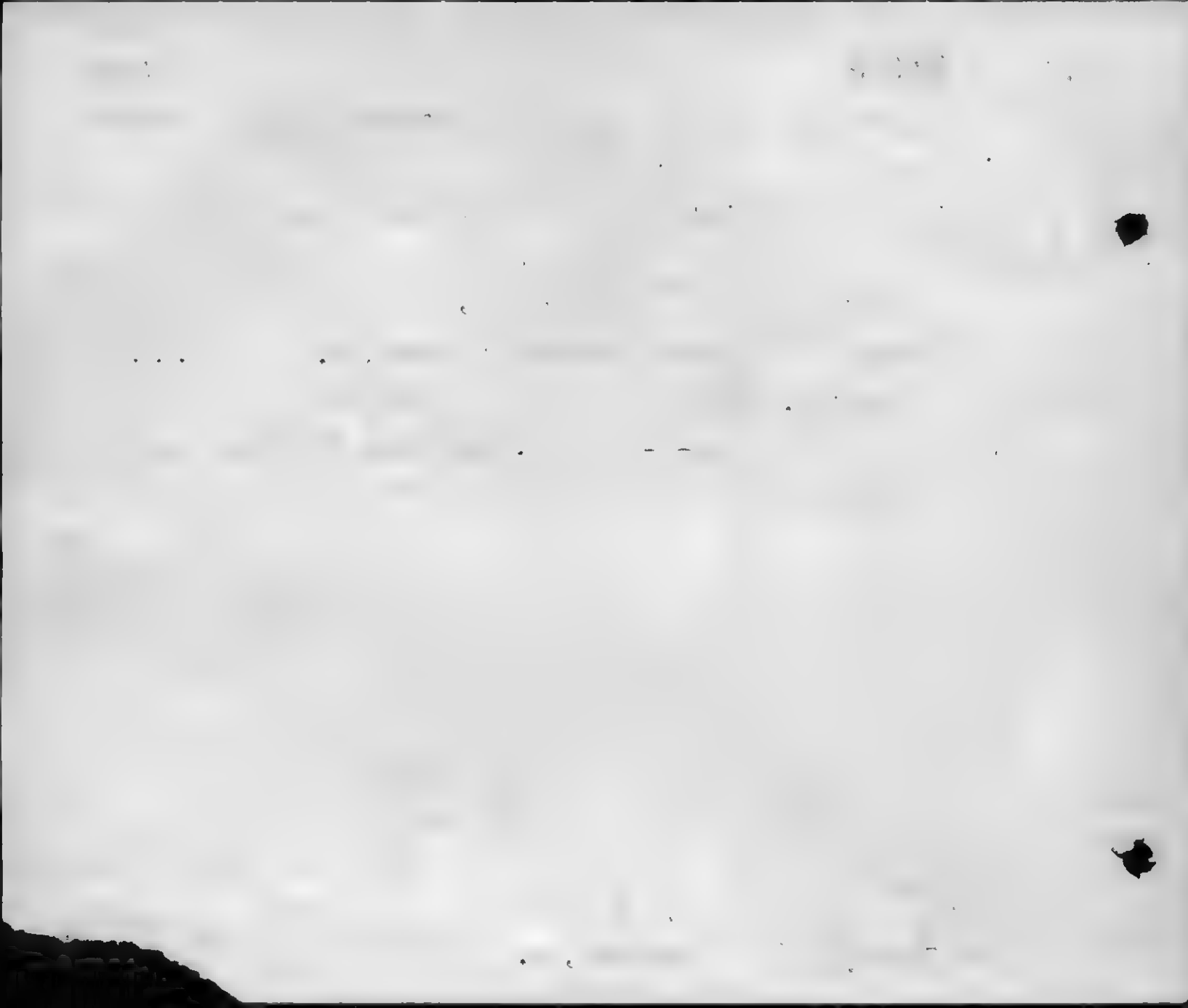
VR A15 (4)  
15M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

13173

13160

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>/210 Alexander Street</u>	
3. NAME OF DECEASED (Type or print) First <u>ROY</u> Middle <u>PRESTON</u> Last <u>JACOBS</u>		4. DATE OF DEATH Month <u>November</u> Day <u>16</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 28, 1893</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Baker</u>		12. BIRTHPLACE (County & State, or foreign country) <u>Fairchild Aircraft Tilghmanton, Md.</u>	
13. FATHER'S NAME <u>Benjamin F. Jacobs</u>		14. MOTHER'S MAIDEN NAME <u>Lida Wade</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-05-6023A</u>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> <u>443X</u> DUE TO (b) <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Hypertensive C-V Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>2 days</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 12, 1956</u> to <u>Nov. 16, 1961</u> , that (I) (we) last saw the deceased alive on <u>Nov. 16, 1961</u> , and that death occurred <u>8:45 A.M.</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>L. L. Packer Jr.</u>		22b. DATE SIGNED <u>11/17/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. L. Packer Jr.</u>		22d. ADDRESS <u>145 W. Washington</u> <u>Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/18/1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Enter Bouzer Funeral Home</u>		25. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13174

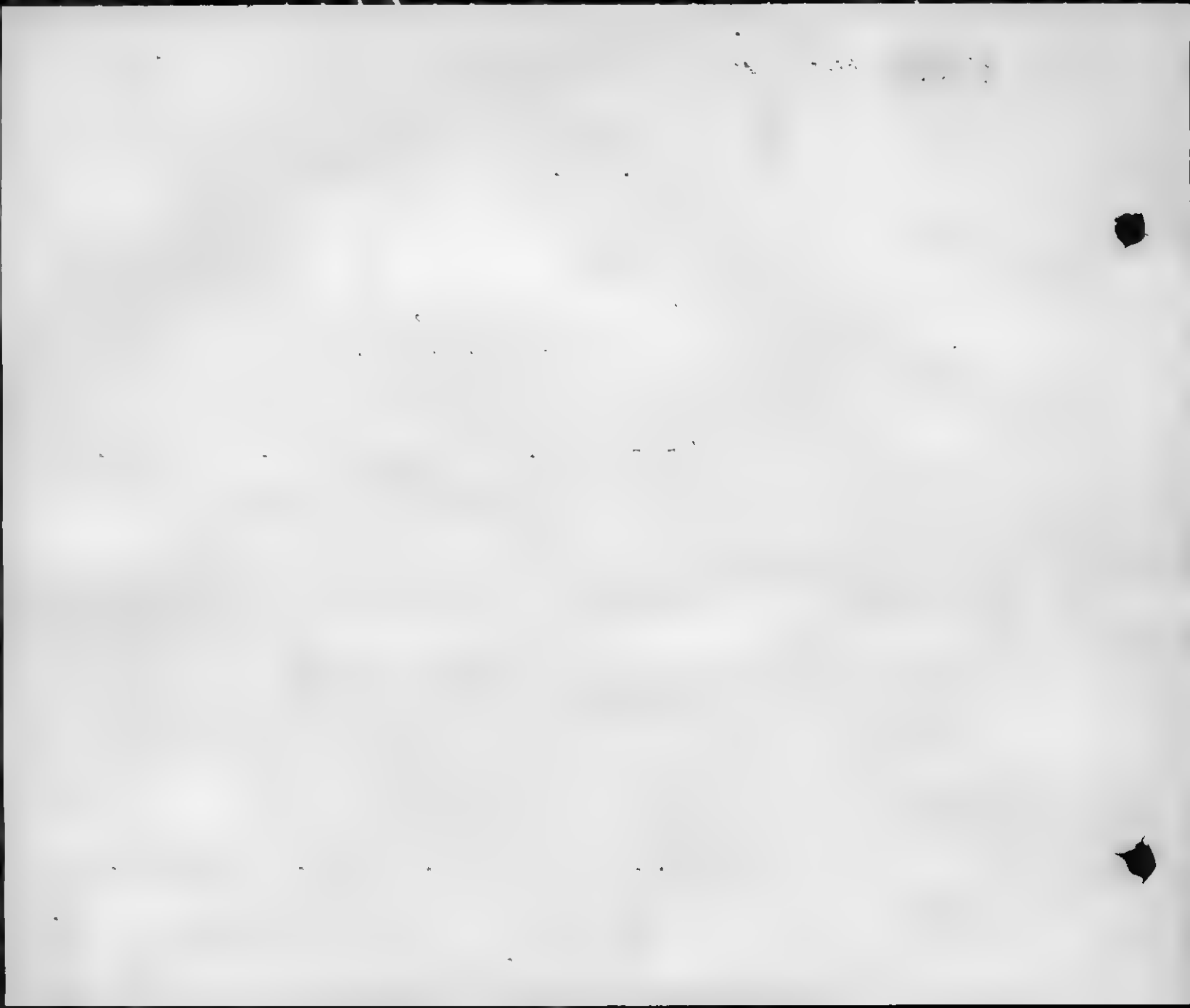
13161

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> c. LENGTH OF STAY IN <u>1 yr. 5 mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Williamsport Sanitarium</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Hagerstown Rural</u> d. STREET ADDRESS <u>1 R # 5</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Benjamin Nathaniel Jamison</u> 5 SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		<b>4. DATE OF DEATH</b> <u>November 30 1961</u> 8. DATE OF BIRTH <u>January 23, 1882</u> 9. AGE (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Die Caster</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Pipe organ supplies</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Chesnut Grove, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Henry Jamison</u> 14. MOTHER'S MAIDEN NAME <u>Mary Ann Ainsworth</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>214-09-3467</u> 17. INFORMANT <u>Wm. Jales</u> Address <u>636 Mulberry St. Hagerstown, Md.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause pertaining to (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>181.0</u> DUE TO <u>Carcinoma of Bladder</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Arteriosclerotic heart disease</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>		20c. TIME OF INJURY Month, Day, Year <u>June 19 1961</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u> 20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>	
21. I certify that (1) (this hospital) attended the deceased from <u>June 1961</u> to <u>Nov 30, 1961</u> , that (1) (we) last saw the deceased alive on <u>Nov 1, 1961</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Paul Harrison</u> 22c. PHYSICIAN'S NAME (Type) <u>Paul Harrison M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>11/30/61</u> 22d. ADDRESS <u>318 N. Potomac St. Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>12/2/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u> 23d. LOCATION (City, town or county) <u>Hagerstown</u> (State) <u>Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Horst</u> ADDRESS <u>Hagerstown, Md.</u> 25a. REC'D BY REGISTRAR <u>DEC 4 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thayer</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13175

13162

<b>1. PLACE OF DEATH</b> a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TREGO - RURAL</u> c. LENGTH OF STAY IN b. <u>40 YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>KEEDYSVILLE MD. R.I.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TREGO - RURAL</u> d. STREET ADDRESS <u>KEEDYSVILLE MD. R.I.</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>THOMAS</u> <u>JAMISON</u> First Middle Last		<b>4. DATE OF DEATH</b> <u>NOVEMBER 1 - 1961</u> Month Day Year	
<b>5. SEX</b> <u>MALE</u> <b>6. COLOR OR RACE</b> <u>WHITE</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>APRIL 23 - 1882</u> Yrs. <u>79</u>		<b>9. AGE</b> (In years last birthday) <u>79</u> yrs. <b>10. IF UNDER 1 YEAR</b> Months <u>6</u> Days <u>8</u> <b>11. IF UNDER 24 HRS.</b> Hours <u>6</u> Min. <u>8</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER AND BOO RR. EMPLOYEE</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>CHESTNUT GROVE WASH. CO. MD. U.S.A.</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>12. CITIZEN OF WHAT COUNTRY?</b>		<b>13. FATHER'S NAME</b> <u>NO RECORD</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>NO RECORD</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>219-14-8172</u> <b>17. INFORMANT</b> <u>MRS. DAISY JAMISON</u> Address <u>KEEDYSVILLE MD. R.I.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Acute myocardial infarct</u> <u>1120.1</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (b) <u>1120.1</u> (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>many years</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from June 1, 1961, to Nov 1, 1961, that (I) (we) last saw the deceased alive on Nov 1, 1961, and that death occurred 10 PM, from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Joseph Secundari</u> M.D.		<b>22b. DATE SIGNED</b> <u>11-2-1961</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>JOSEPH SECONDARI</u>		<b>22d. ADDRESS</b> <u>BOONSBORO MD</u>	
<b>23a. BURIAL, CREMATION, OR REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>NOV. 5, 1961</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>MT. ZION CEMETERY</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>LOCUST GROVE WASH. CO. MD.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John H. Bart</u>		<b>25a. REC'D BY REGISTRAR</b> <u>Boonsboro MD</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Hume</u>		<b>DATE</b> <u>NOV 8 '61</u>	

MEDICAL CERTIFICATION



FOR STATE  
HEALTH DEPT.

TO NOTIFY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

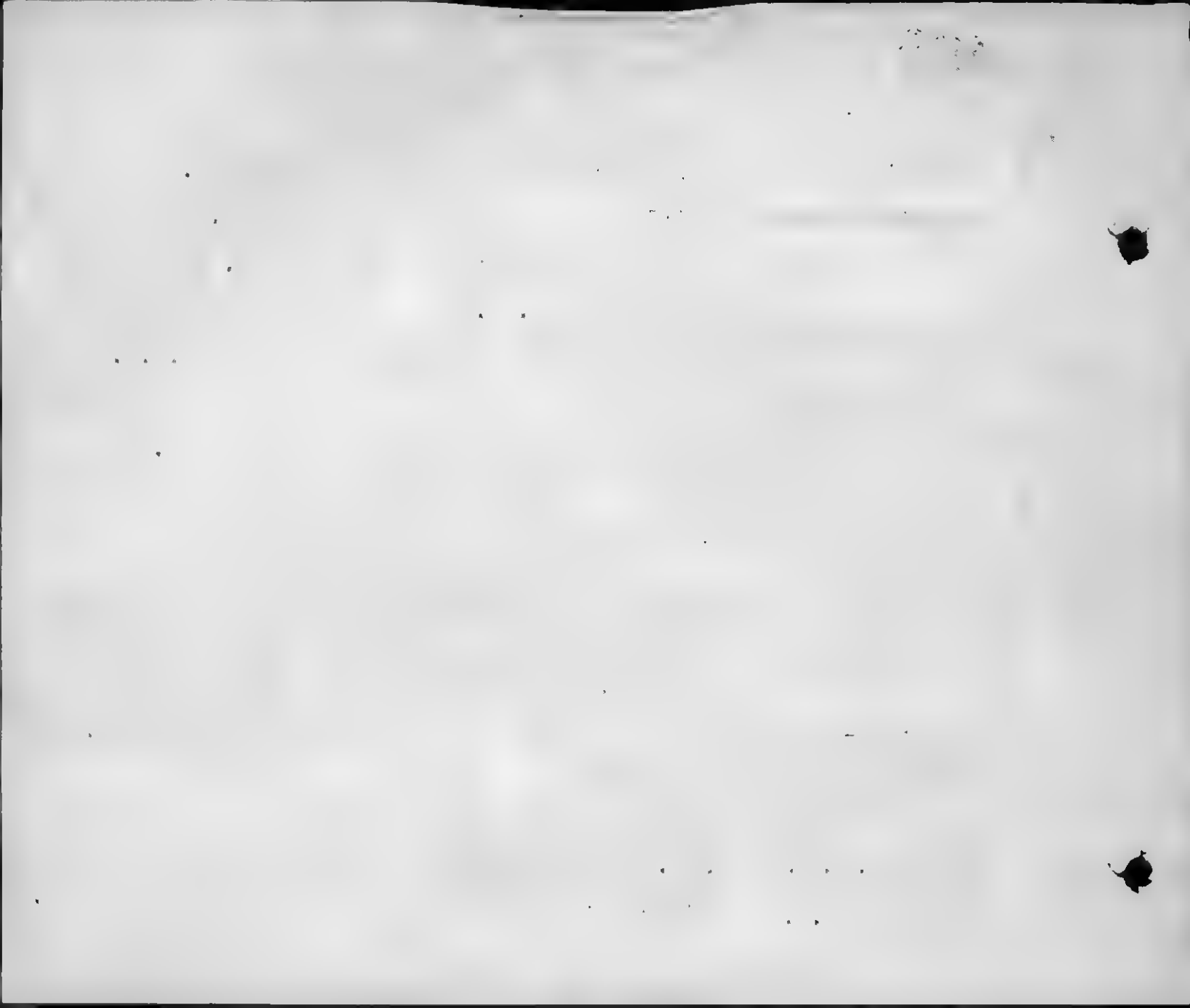
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film 9302 12/12/61 iwr

14522

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN b <b>15 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural 2 Hancock Md.</b> d. STREET ADDRESS <b>Rural 2 Hancock Md.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Emma Kate Keefer</b>		4. DATE OF DEATH <b>11. 30. 19 61</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4.10.1867</b>
9. AGE (In years last birthday) <b>94</b> yrs.		10. AGE (In years last birthday) <b>94</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Hancock Maryla nd</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Isaac Younker</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Hull</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Ray Grove</b>		Address <b>Rural 2 Hancock Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Uremia</b> <b>704.0</b> DUE TO Conditions, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fracture Right Hip</b> DUE TO (c) <b>Hypertensive Cardio Vascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>14 days</b> <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell in home.</b>	
20c. TIME OF INJURY Month, Day, Year <b>11-11-19 61</b> Hour <b>11</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Hancock, Washington, Md.</b> (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>[Signature]</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. E. W. Ditto, Jr.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>12-1-61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12.3.61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Stone Bridge Brethern</b>		22d. LOCATION (City, town, or country) <b>Rural Hancock Washington Md.</b>	
23. FUNERAL DIRECTOR <b>Howard J. Elmer Hancock Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 8 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13177

## CERTIFICATE OF DEATH

Reg. Dist. No. 13163

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>05 HAGERSTOWN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. COUNTY HOSPITAL</u>				d. STREET ADDRESS <u>1 603 HAYES AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>KENDALL</u>				4. DATE OF DEATH Month Day Year <u>NOVEMBER 5 1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOVEMBER 5 1961</u>	
9. AGE (In years last birthday) yrs. <u>5</u>		IF UNDER 1 YEAR Months Days Hours Min <u>5 14</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>GENE EDWARD KENDALL</u>				14. MOTHER'S MAIDEN NAME <u>NANCY LEE HAY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MOTHER</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> <u>162.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Immaturity</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>6 14/40 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Hagerstown, Md.</u>				20g. (County) (State)			
21. I certify that I attended the deceased from <u>11-5</u> , 19 <u>61</u> , to <u>11-5</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>11-5</u> , 19 <u>61</u> , and that death occurred at <u>7:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. F. Woodrill</u>				ADDRESS (Street, city or town, state) <u>115 King St., Hagerstown, Md.</u>			
DATE SIGNED <u>Nov 11 1961</u>							
PHYSICIAN'S NAME (Type) <u>DR. S. F. WOODRILL</u>				<u>HAGERSTOWN, MD.</u>			
22a. BURIAL (CREMATION, REMOVAL) (Specify)		22b. DATE THEREOF <u>11-9-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>W. C. H.</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Schaffer</u>				ADDRESS <u>Wash. Co. Hospital</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 13 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thane</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 may be retained by the hospital or attending physician.

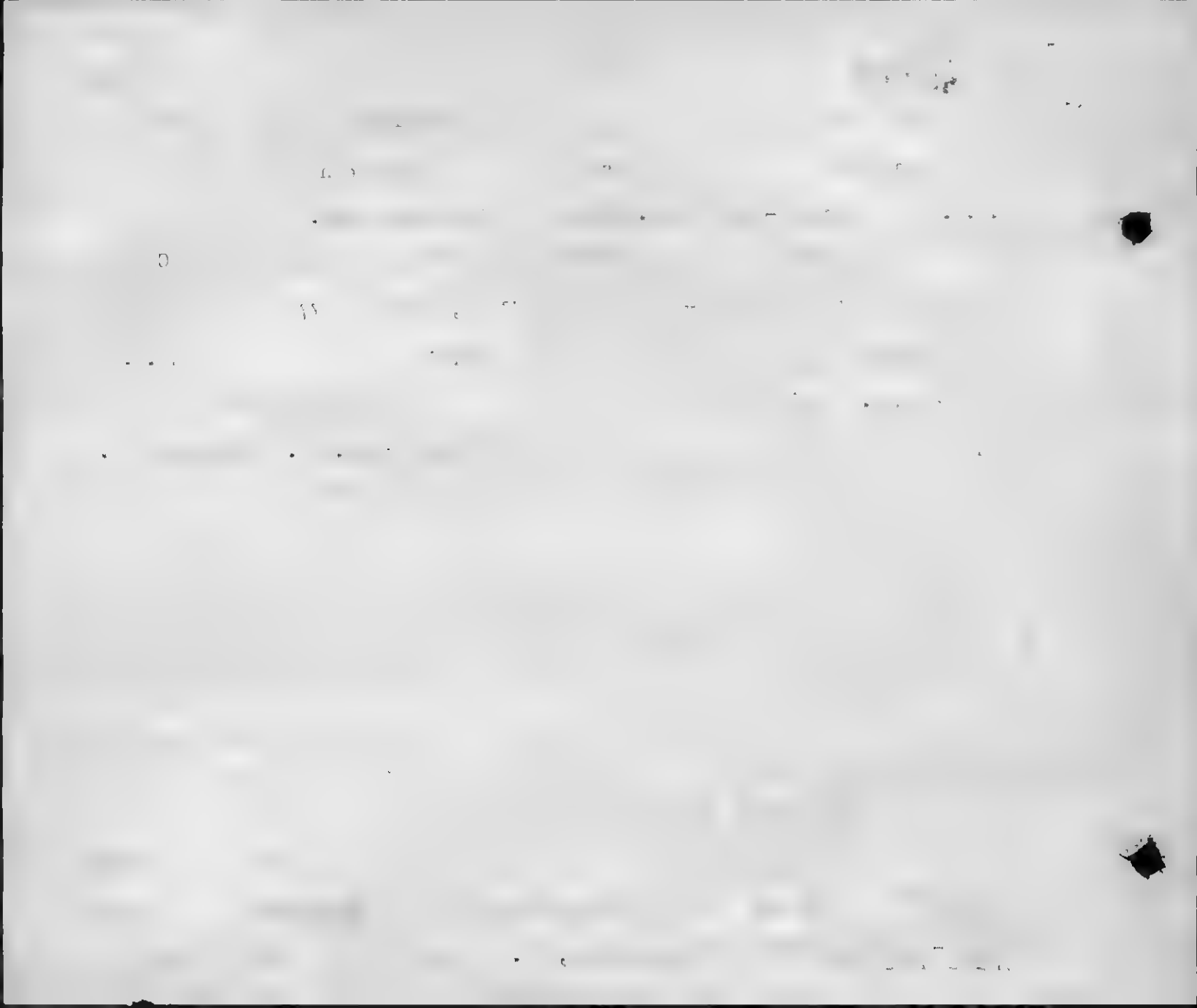
VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Boonsboro</b> c. LENGTH OF STAY IN b. <b>39 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R.F.D. # 2 Fahrney - Keedy Mem. Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>61 Randolph Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>FIRMIENE JOSEPHINE LAMBILLOTTE</b>		4. DATE OF DEATH <b>November 29 19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 29, 1884</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR: Months <b>29</b> Days <b>19</b> Hours <b>61</b> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John B. Lambillotte</b>		14. MOTHER'S MAIDEN NAME <b>Julienne Trefois</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>George Lambillotte, Jr. Hagerstown, Md.</b>	
17. INFORMANT <b>George Lambillotte, Jr. Hagerstown, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>4</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (b) <b>6 months</b> DUE TO (c) <b>Interval between ONSET and DEATH</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)	
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 1</b> , 19 <b>61</b> , to <b>Nov. 20</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Nov. 20</b> , 19 <b>61</b> , and that death occurred at <b>10 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>G. W. Heelan</b>		22b. DATE SIGNED <b>Nov. 20</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. W. Heelan</b>		22d. ADDRESS <b>Boonsboro Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/24/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>R. st Haven Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hagerstown Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Suter - Rouzer Funeral Home</b>		25a. REC'D BY REGISTRAR <b>NOV 27 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>R. Franklin Boyer</b>		25c. REGISTRAR'S SIGNATURE <b>Clifton L. Kraus</b>	



CERTIFICATE OF DEATH

13179

13165

1. PLACE OF DEATH  
e. COUNTY **WASHINGTON** MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **HAGERSTOWN**  
c. LENGTH OF STAY IN 1b **64 YEARS**  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **WASHINGTON COUNTY HOSPITAL**

2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
a. STATE **MARYLAND** b. COUNTY **WASHINGTON**  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **HAGERSTOWN**  
d. STREET ADDRESS **672 HIGHLAND WAY**  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) **JOHN CHARLES LEWIS**  
4. DATE OF DEATH **NOV. 5 1961**  
5. SEX **MALE** 6. COLOR OR RACE **WHITE** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **AUG 4 1896**  
9. AGE (in years, last birthday) **65 yrs.** IF UNDER 1 YEAR: Months **65** Days **5** Hours **19** Min. **61**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **RETIRED CONDUCTOR**  
10b. KIND OF BUSINESS OR INDUSTRY **RAILROAD**  
11. BIRTHPLACE (County & State, or foreign country) **JEFFERSON W. VIRGINIA**  
12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **UNKNOWN**  
14. MOTHER'S MAIDEN NAME **UNKNOWN**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **NO** 16. SOCIAL SECURITY NO. **214-09-6039** 17. INFORMANT **MRS. OLIVE G LEWIS** Address **HAGERSTOWN MARYLAND**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **Chronic Pulmonary Edema**  
(b) **Cor Pulmonale**  
(c) **Partial occlusion and thrombus in right main pulmonary artery (Thrombus 2 mons)**  
Interval between onset and death **30 days**  
**3 1/2 years**  
**3 1/2 years plus**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)  
**Infarct, spleen and kidney**

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. **19**  
20d. INJURY OCCURRED While at work ☐ Not While at work ☐  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  
20f. (City or town) (County) (State)

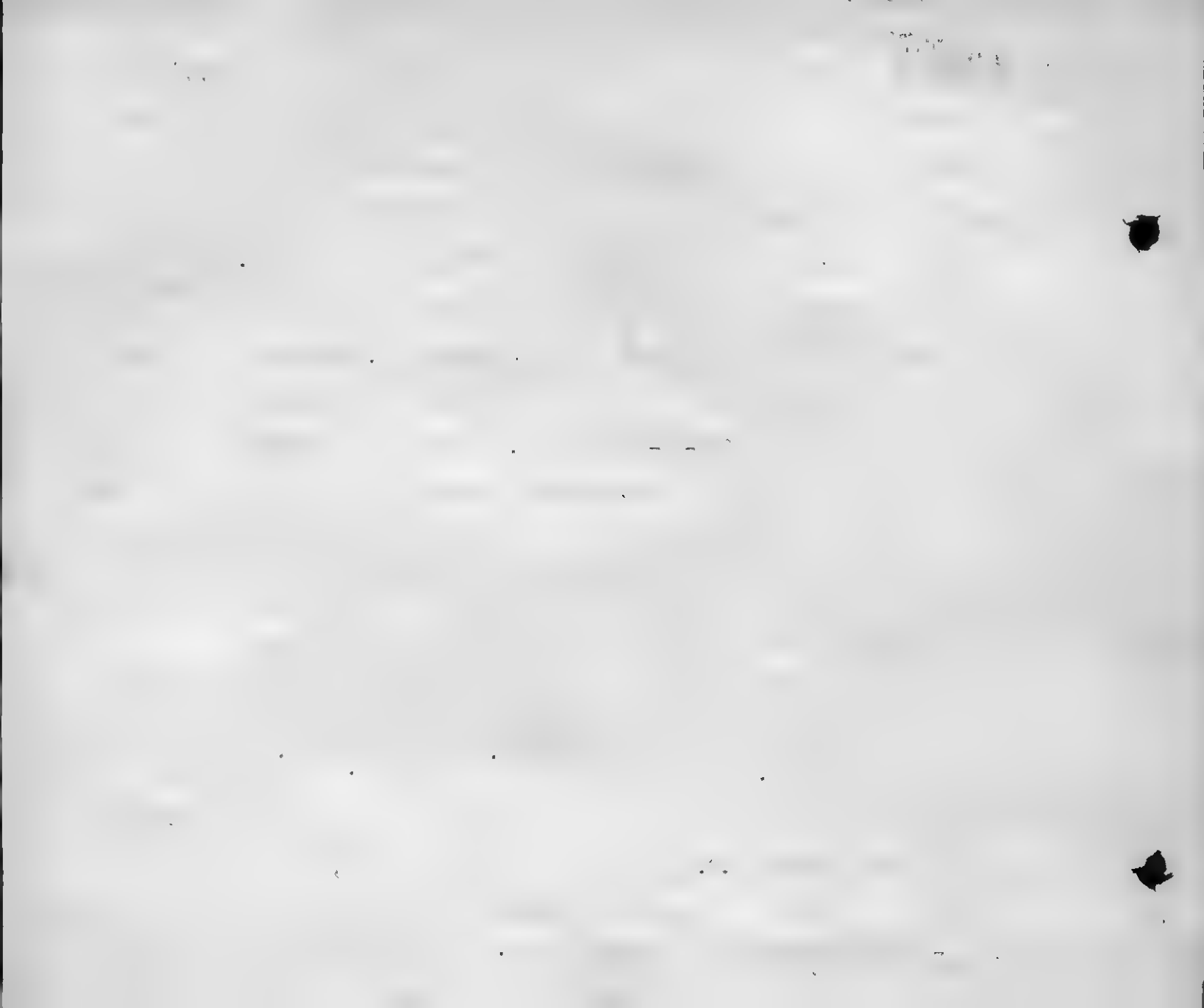
21. I certify that (I) (his hospital) attended the deceased from **Oct. 3 1961** to **Nov. 4 1961**, that (I) (we) last saw the deceased alive on **Nov. 4 1961**, and that death occurred at **5:55 am**, from the causes and on the date stated above.

22a. SIGNATURE **WILLIAM T LAYMAN** M.D. 22b. DATE SIGNED **11-6-61**  
22c. PHYSICIAN'S NAME (Type) **WILLIAM T LAYMAN** M.D.  
22d. ADDRESS **5 Public Square Hagerstown, Maryland**

23a. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL** 23b. DATE THEREOF **11/7/61**  
23c. NAME OF CEMETERY OR CREMATORY **ROSE HILL CEMETERY** 23d. LOCATION (City, town or county) (State) **HAGERSTOWN MARYLAND**

24. FUNERAL DIRECTOR'S SIGNATURE **Superior Funeral Home** ADDRESS **HAGERSTOWN MD.**  
25a. REC'D BY REGISTRAR **NOV 8 '61** 25b. REGISTRAR'S SIGNATURE **Arthur S. Sims**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1  
**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13180

13166

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Martin Manor Rest Home</b>				d. STREET ADDRESS <b>25 E. Baltimore St.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Nellie Boyd Linebaugh</b>				4. DATE OF DEATH Month <b>November</b> Day <b>3</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 3, 1875</b>	
9. AGE (In years or birthday) <b>86</b> yrs		IF UNDER 1 YEAR Months <b>8</b> Days <b>6</b> Hours <b>0</b> Min <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>John Boyd</b>				14. MOTHER'S MAIDEN NAME <b>Elenora Suter</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>----</b>		17. INFORMANT <b>Charles E. Linebaugh Jr.</b> Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> 1200 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <b>10-30-61</b> to <b>11-3-61</b> , 19____, that (I) (we) last saw the deceased alive on <b>10-30-61</b> , 19____, and that death occurred at <b>6</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Paul Harrison</b>				22b. DATE SIGNED <b>11-3-61</b>		22c. PHYSICIAN'S NAME (Type) <b>Paul Harrison, M. D.</b>	
22d. ADDRESS <b>318 N. Potomac St., Hagerstown, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-6-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son Hagerstown, Md.</b>				25a. REC'D BY REGISTRAR <b>NOV 7 '61</b>		25b. REGISTRAR'S SIGNATURE <b>William S. House</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

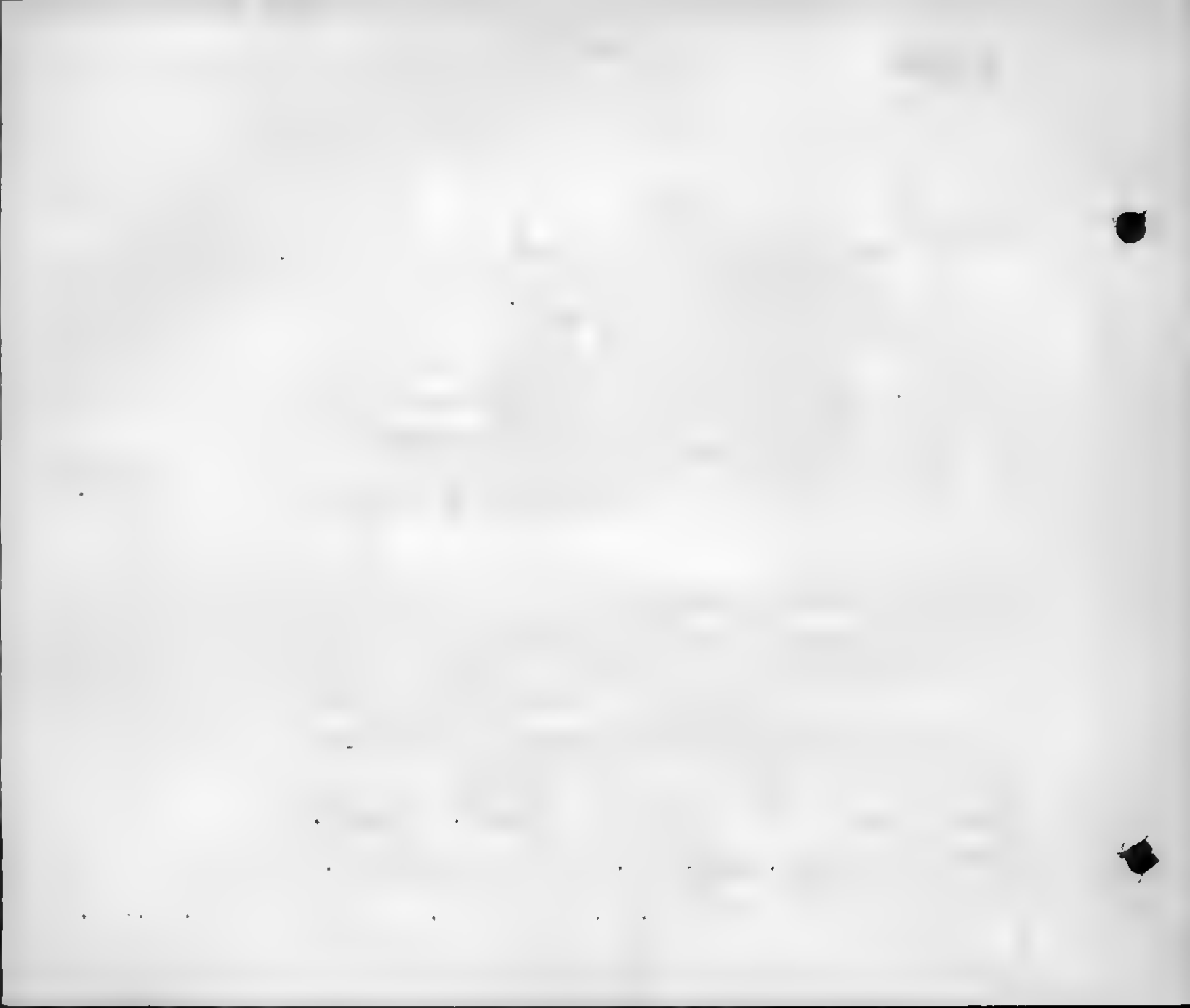
Inf. from birth certificate 12/22/61 iwk

# CERTIFICATE OF DEATH

Reg. Dist. No. 14529

13181

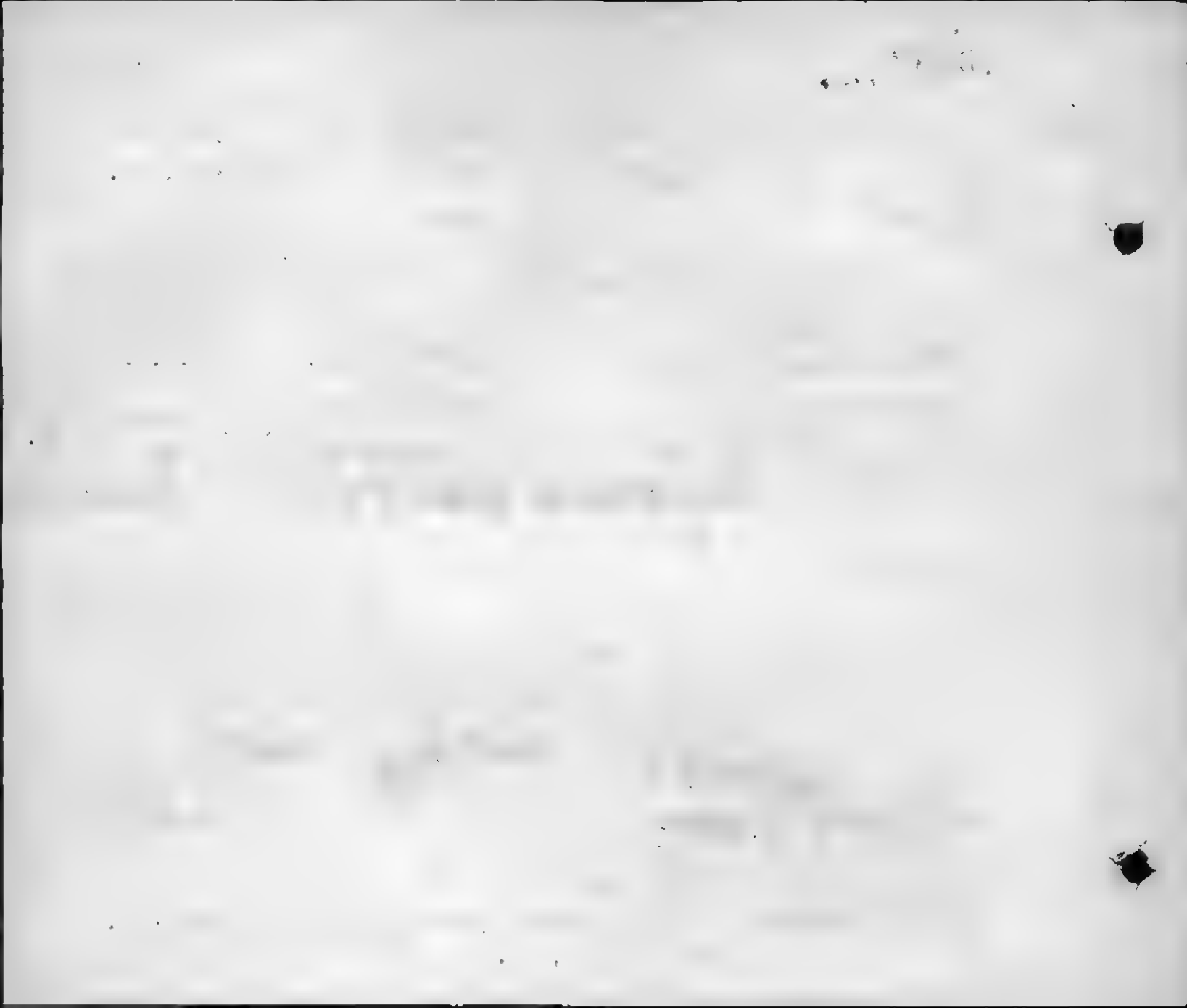
1. PLACE OF DEATH a. COUNTY <b>Washington County</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Penna</b> b. COUNTY <b>Franklin</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greencastle</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		d. STREET ADDRESS <b>Route #2</b>	
3. NAME OF DECEASED (Type or print) First <b>BABY GIRL</b> Middle <b>LOWERY</b> Last		4. DATE OF DEATH Month <b>Nov. 18, 1961</b> Day <b>19</b> Year	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 18, 1961</b>
9. AGE (In years last birthday) <b>35</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles F. Lowery</b>		14. MOTHER'S MAIDEN NAME <b>Frances Lee Wolford</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Medical Record</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <b>776X</b> DUE TO <b>Immunity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>35 min.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased <b>Nov. 11-18-61</b> , 19___, to <b>11-18-61</b> , 19___, that I last saw the deceased alive on <b>11-18-61</b> , 19___, and that death occurred at <b>4:55 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Howard N. Weeks</b>		ADDRESS (Street, city or town, state) <b>136 N. Potomac St.</b>	
PHYSICIAN'S NAME (Type) <b>Howard N. Weeks, M. D.</b>		DATE SIGNED <b>12/15/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>11-19-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Wash. Co. Hospital Lab.</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Wash. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Schaffer, Adm.</b>		24a. REC'D BY REGISTRAR <b>DEC 22 '61</b>	
ADDRESS <b>Wash. Co. Hospital</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Haines</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician and completed by the attending physician and completed by the attending physician and completed by the attending physician. After this certificate has been signed by the attending physician and completed by the attending physician, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 7, 61

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
13182									
13167									
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROUTE 1</b>					c. LENGTH OF STAY IN 1b <b>LIFE</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RESIDENCE</b>					d. STREET ADDRESS <b>NONE</b>				
3. NAME OF DECEASED (Type or print) <b>SUSAN LOUISE MASON</b>					4. DATE OF DEATH <b>11 28 19 61</b>				
5. SEX <b>FEMALE</b>					6. COLOR OR RACE <b>WHITE</b>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>3/1/61</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>				
11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON CO.</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>JAMES MASON</b>					14. MOTHER'S MAIDEN NAME <b>CATHERINE MILLS</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>NO</b>					16. SOCIAL SECURITY NO. <b>NONE</b>				
17. INFORMANT <b>MRS CATHERINE MILLS PERKINS</b>					18. ADDRESS <b>RD. 1, CLEAR SPRING, MD.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last (c) <b>Aspiration Vomitus</b>					INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <b>11/28/61</b> to <b>11/28/61</b> , that (I) (we) last saw the deceased alive on <b>11/28/61</b> , and that death occurred on <b>11/28/61</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Ralph T. Young</b>									
22b. DATE SIGNED <b>11/28/61</b>									
22c. PHYSICIAN'S NAME (Type) <b>Ralph T. Young</b>									
22d. ADDRESS <b>CLEAR SPRING, MD.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>									
23b. DATE THEREOF <b>11/30/61</b>									
23c. NAME OF CEMETERY OR CREMATORY <b>CLEAR SPRING MENNONITE</b>									
23d. LOCATION (City, town or county) (State) <b>CLEAR SPRING, MD.</b>									
24. FUNERAL DIRECTOR'S SIGNATURE <b>Margaret R. Rowland</b>									
25a. REC'D BY REGISTRAR <b>DEC 1 '61</b>									
25b. REGISTRAR'S SIGNATURE <b>Clifford L. Hanks</b>									

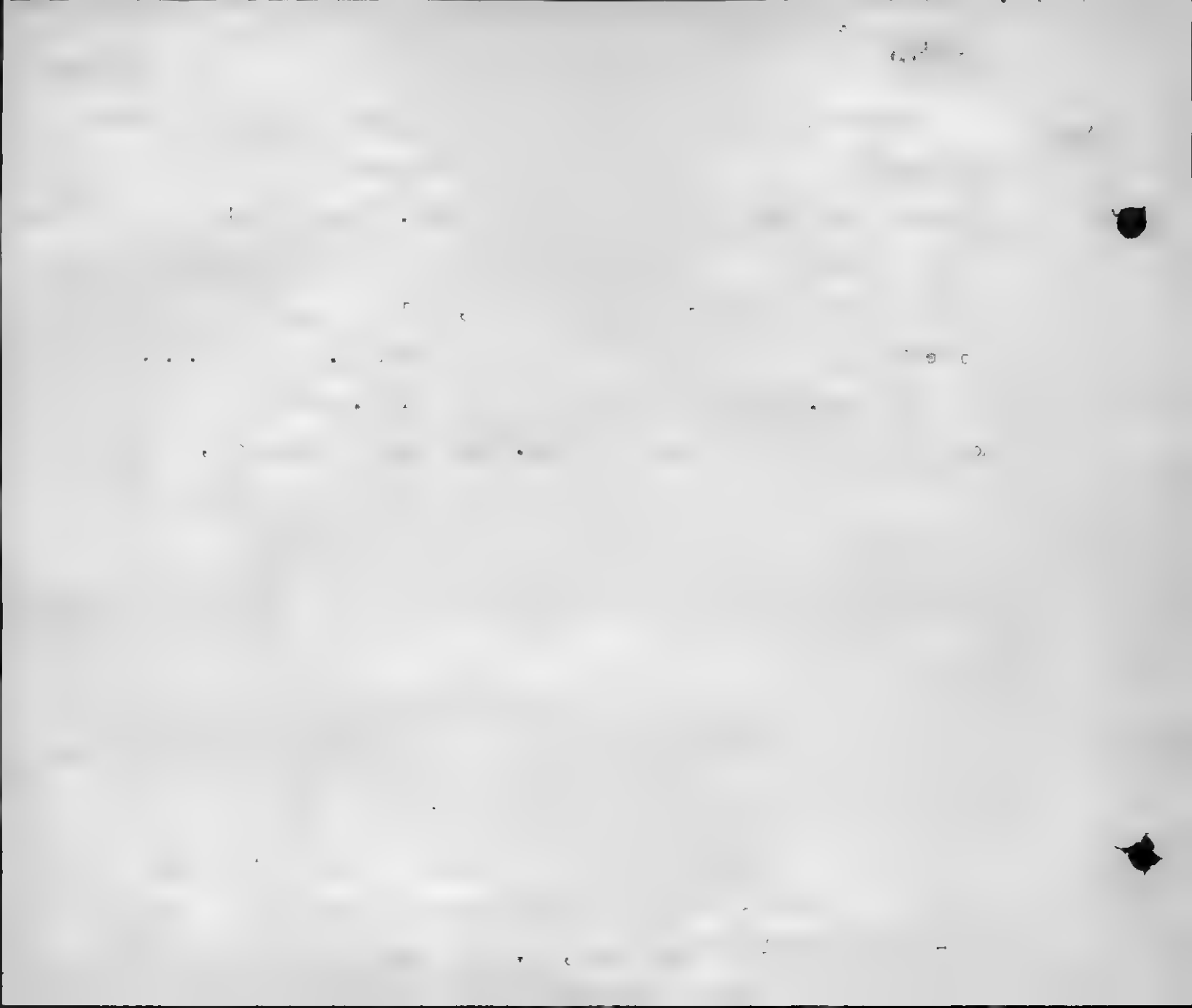


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
13183 CERTIFICATE OF DEATH 13168

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN life <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Homewood Church Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>457 N. Potomac Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <b>GARRIE GOOD</b>	4. DATE OF DEATH <b>November 24 19 61</b>	5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 25, 1871</b>	9. AGE (In years last birthday) <b>90 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown, Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel M. Good</b>	14. MOTHER'S MAIDEN NAME <b>Mary E. Seibert</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Mrs. Fred Reynolds</b>	Address <b>Hagerstown, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular collapse</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerosis - gen.</b> (c) <b>Thyroid adenoma.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Thyroid adenoma.</b>								INTERVAL BETWEEN ONSET AND DEATH <b>min</b> <b>yr</b>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 61</b> to <b>11/24</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Oct 61</b> , 19 <b>61</b> , and that death occurred at <b>11/24</b> , 19 <b>61</b> , from the causes and on the date stated above.										
22a. SIGNATURE <b>Louis G. Graff</b>		22b. DATE SIGNED <b>11/24/61</b>		22c. PHYSICIAN'S NAME (Type) <b>Louis G. GRAFF</b>		22d. ADDRESS <b>111 E. Antietam</b>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/26/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hagerstown Maryland</b>		23e. REC'D BY REGISTRAR <b>NOV 29 '61</b>		23f. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Suter - Rouzer Funeral Home</b>										24b. ADDRESS <b>Hagerstown, Md.</b>

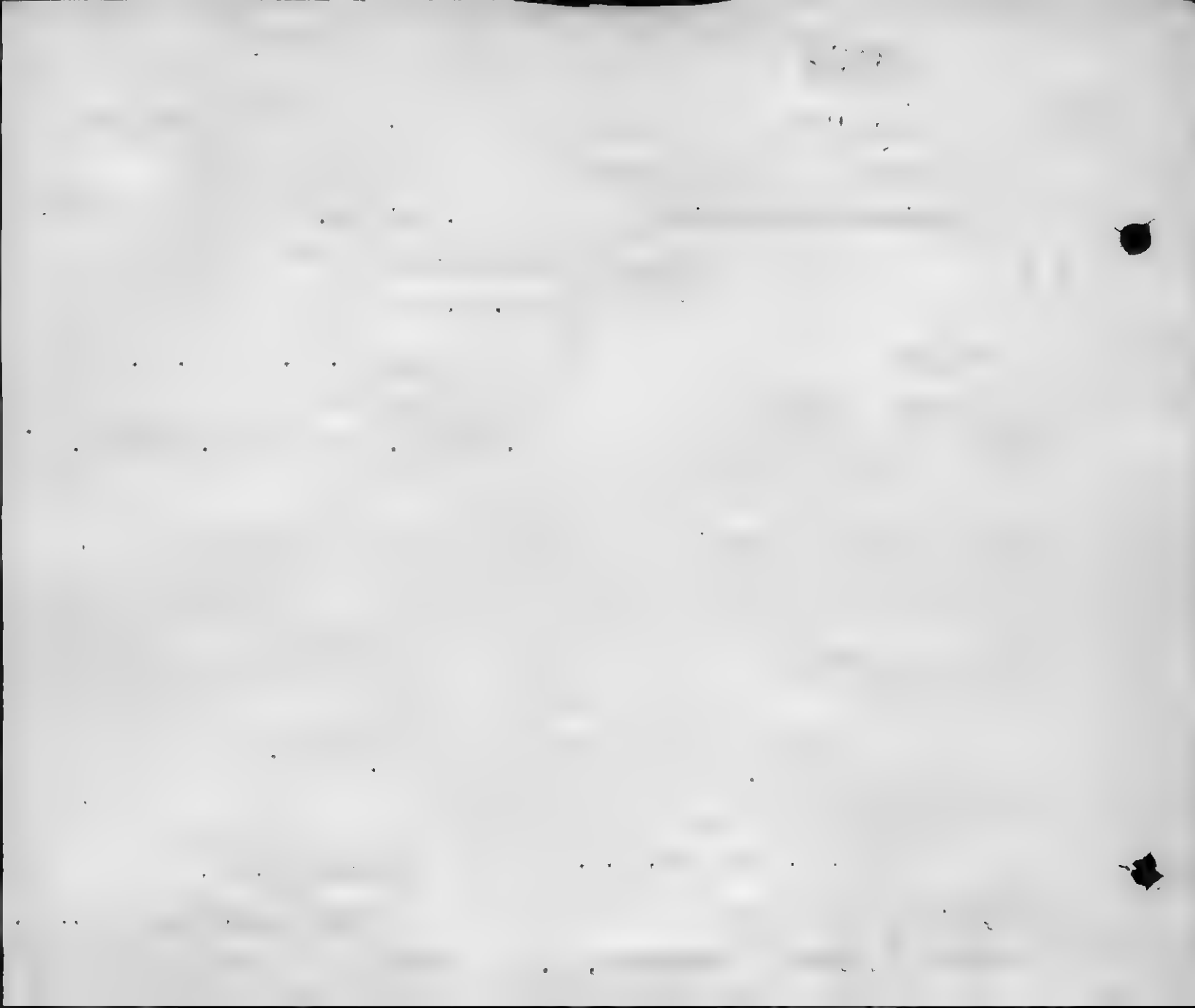


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completed by filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
13184 CERTIFICATE OF DEATH 13169			
1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN It <b>19 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>70 E. Irvin Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lutie Kendall McGlaughlin</b>		4. DATE OF DEATH Month <b>November</b> Day <b>27</b> Year <b>1961</b>	
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 14, 1894</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hous wife</b>		12. BIRTHPLACE (County & State, or foreign country) <b>Washington Co. Md.</b>	
13. FATHER'S NAME <b>Abraham Kendall</b>		14. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Ida Toms</b>	
17. INFORMANT <b>Mrs. Harold C. Trovinger</b>		Address <b>70 E. Irvin Ave. Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>General carcinomatosis</b> 153.0 DUE TO (b) <b>Carcinoma of the cecum and ascending colon</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>2 1/2 yr.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Indefinite</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 19 8:25 AM</b> to <b>Nov. 27, 1961</b> that (I) (we) last saw the deceased alive on <b>Nov. 26, 1961</b> , and that death occurred at <b>11:27 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>B. B. Kneisley</b>		22b. DATE SIGNED <b>11/27/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M.D.</b>		22d. ADDRESS <b>148 West Washington Street Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/29/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven</b>		23d. LOCATION (City, town or county) (State) <b>Hagerstown, Washington Co., Md.</b>	
24a. FUNERAL DIRECTOR'S SIGNATURE <b>Waynesboro, Pa.</b>		25a. REC'D BY REGISTRAR <b>NOV 30 '61</b>	
25b. REGISTRAR'S SIGNATURE		25c. DATE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1

13185

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13170

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. STREET ADDRESS <b>524 Salem Ave.</b>			
3. NAME OF DECEASED (Type or print) <b>John William Middlekauff</b>				4. DATE OF DEATH <b>November 18 19 61</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Aug. 1, 1877</b>	9 AGE (In years last birthday) <b>84</b> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chief Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John H. Middlekauff</b>				14. MOTHER'S MAIDEN NAME <b>Sarah E. Rouskulp</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>		17 INFORMANT <b>Mrs. Anna Middlekauff</b> Address <b>Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>180X</b> DUE TO <b>Thyroid left kidney &amp; gland metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>General Arteriosclerosis</b> DUE TO <b>General Arteriosclerosis</b> (c) <b>Pneumonia</b> DUE TO <b>Pneumonia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21 I certify that (I) (this hospital) attended the deceased from <b>11-18-61</b> to <b>11-18-61</b> , that (I) (we) last saw the deceased alive on <b>11-18-61</b> , and that death occurred on <b>11-18-61</b> M, from the causes and on the date stated above.						22b. DATE SIGNED	
22a. SIGNATURE <b>A. E. Waitt Jr.</b>		22c. PHYSICIAN'S NAME (Type) <b>A. E. Waitt Jr.</b>		22d. ADDRESS <b>Hagerstown, Md.</b>		22b. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-21-61---</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b> ADDRESS <b>Hagerstown, Md.</b>				25a. REC'D BY REGISTRAR <b>Nov 22 '61</b>		25b. REGISTRAR'S SIGNATURE	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

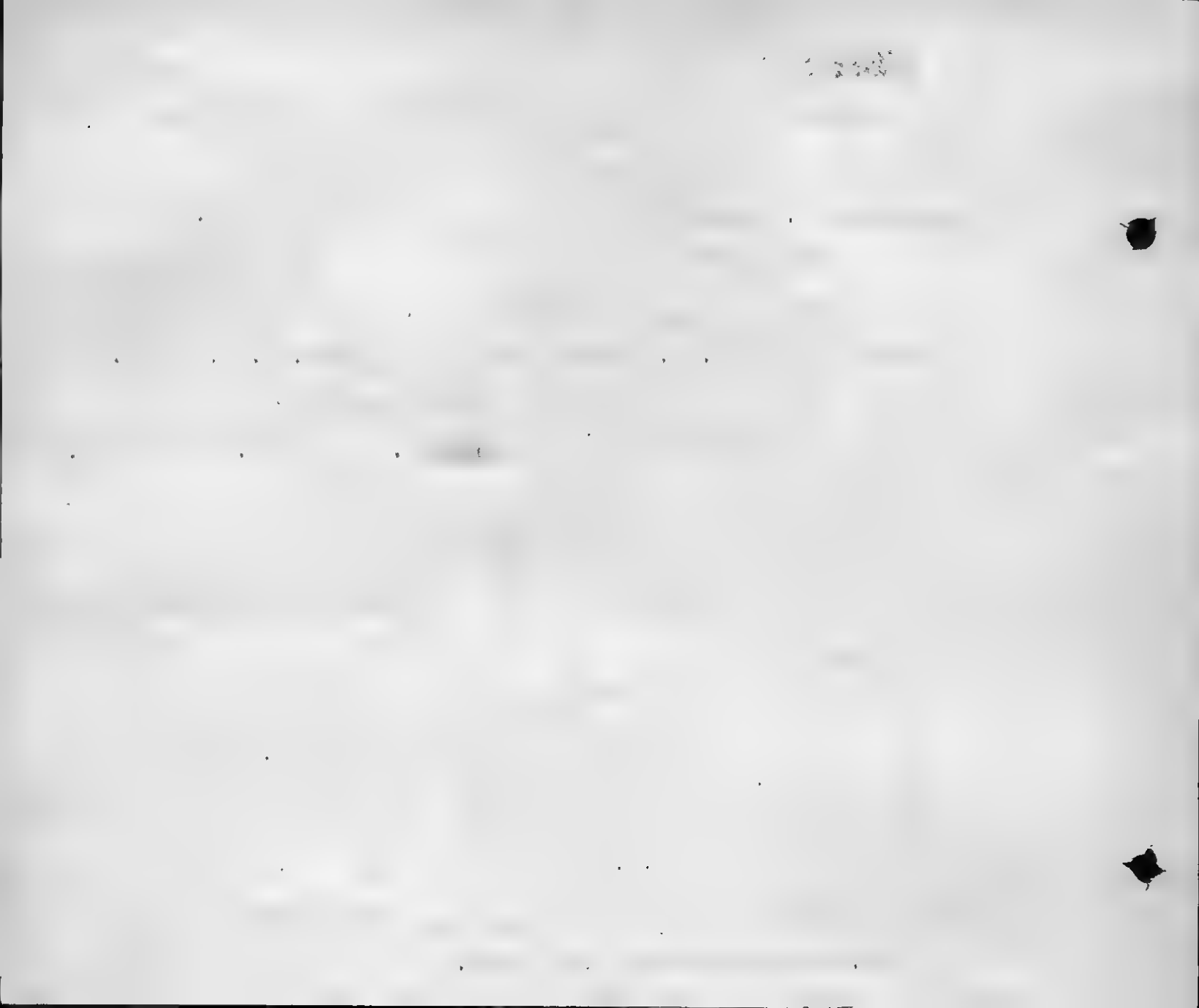
13186

## CERTIFICATE OF DEATH

13171

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>1 week</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Co. Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; has residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>1321 South Mulberry St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>MARY LOUISE MORT</b>		<b>4. DATE OF DEATH</b> <b>November 3, 1961</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>January 19, 1890</b>
<b>9. AGE</b> (In years) <b>71</b> yrs. <b>11</b> months <b>3</b> days <b>1</b> hour <b>0</b> min.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Waitress</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Wash. Co. Hospital Leitersburg, Wash. Co. Md.</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA.</b>	
<b>13. FATHER'S NAME</b> <b>William Mort</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Malinda Dentler</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> <b>16. SOCIAL SECURITY NO.</b> <b>217-28-7355</b> <b>17. INFORMANT</b> <b>Miss Emma K. Mort, 321 S. Mulberry St. Hagerstown, Maryland</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> (b) <b>Art.riosclerotic heart disease</b> (c) <b>Indefinite</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour <b>19</b> a.m. p.m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from July 27, 1961, to Nov. 3, 1961, that (I) (we) last saw the deceased alive on Nov. 3, 1961, and that death occurred at 2 M. from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>B. P. Kreisley, M.D.</b>		<b>22b. DATE SIGNED</b> <b>11/6/61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>B. P. Kreisley, M.D.</b>		<b>22d. ADDRESS</b> <b>148 West Hagerstown St. Hagerstown, Maryland</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>11/6/61</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Rose Hill Cemetery</b>	<b>23d. LOCATION</b> (City, town or county) (State) <b>Hagerstown, Maryland</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Andrew K. Coffman, Hagerstown, Maryland.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>NOV 10 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the attending physician and the funeral director be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

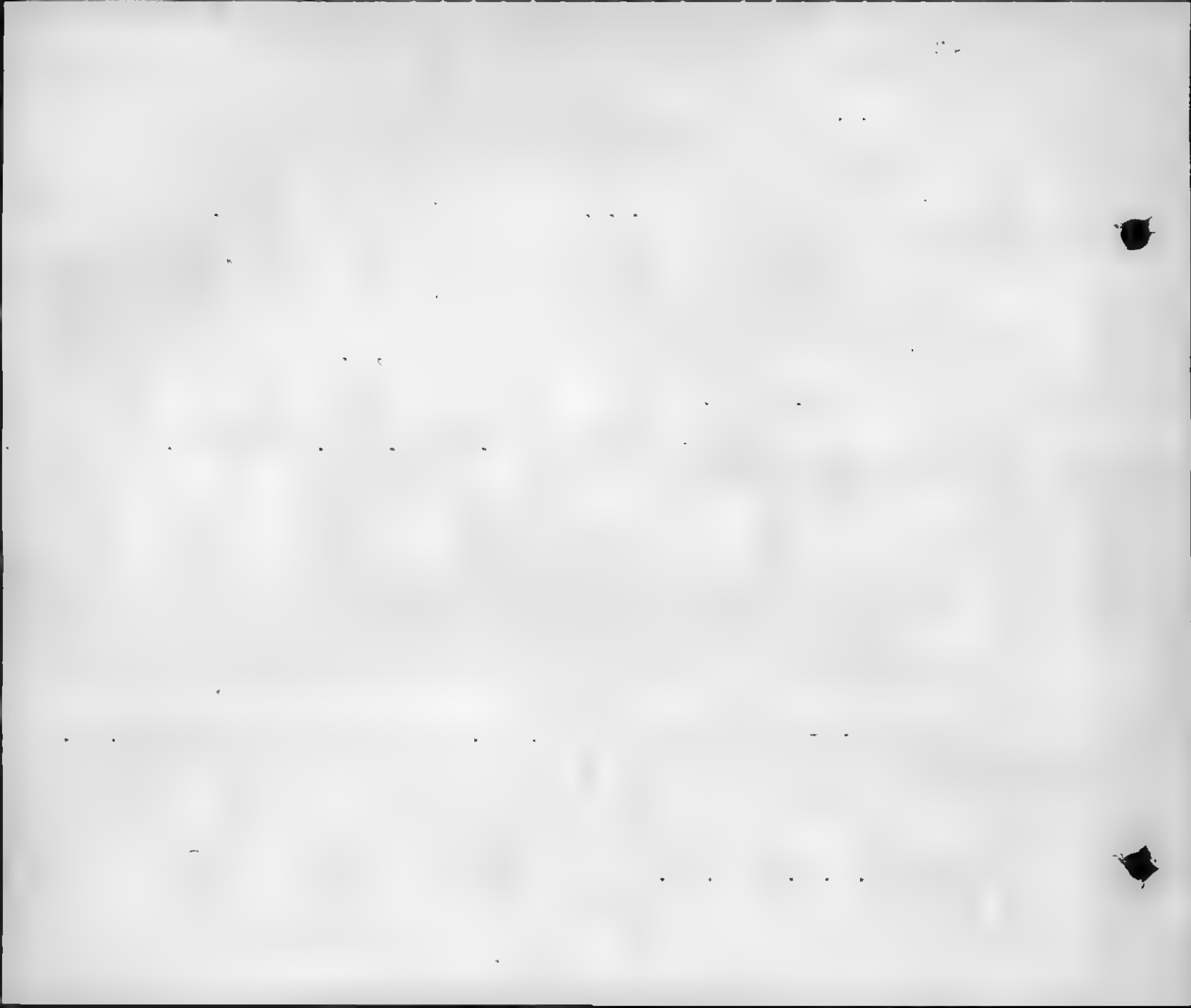
13187

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13172

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital D.O.A.</u>				d. STREET ADDRESS <u>11 West Baltimore St.</u>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Mason</u> Last <u>Mose</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>23</u> Year <u>19 61</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 10, 1942</u>		9. AGE (in years last birthday) <u>19</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Deliveryman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Meat Products</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Carl J. Mose Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Jonice Virginia Artz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-38-1584</u>		17. INFORMANT Address <u>Carl J. Mose Sr. 11 W. Baltimore St. Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Of Skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Crushed Chest Right Side</u> (c) <u>  </u> DUE TO (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Car possibly skidded into path of on coming car.</u>					
20c. TIME OF INJURY Month, Day, Year <u>8:30 p.m. 11-23- 1961</u>		20d. INJURY OCCURRED, While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rt. 34, 3 Mi. South of Sharpsburg, Washington, Md.</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>[Signature]</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 11-24-61			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/26/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. C. Horst</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 28 61</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

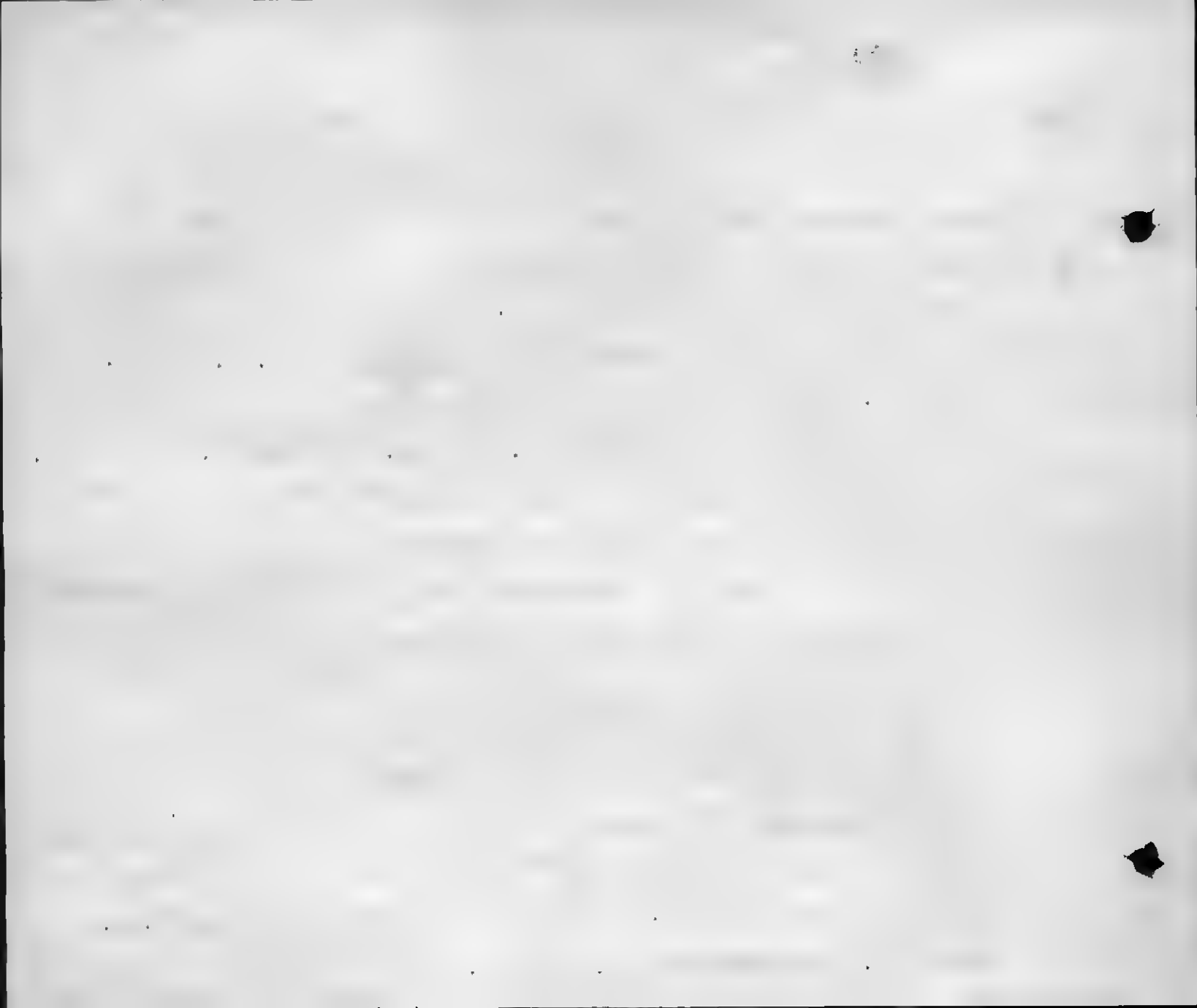
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13188

## CERTIFICATE OF DEATH

13173

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN (b) <b>10 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Western Maryland State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>649 North Mulberry St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Carrie Venora Myrtle</b> 5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>Dec. 29, 1878</b> 9. AGE (In years last birthday) <b>82</b> yrs. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> IF UNDER 24 HRS. <b>0</b>		4. DATE OF DEATH <b>November 27, 1961</b> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Shenandoah, Page Co. Va.</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>James A. Lucas</b> 14. MOTHER'S MAIDEN NAME <b>Susan Gentry</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> 16. SOCIAL SECURITY NO. <b>None</b> 17. INFORMANT <b>Mrs. Mattie L. Entler, 649 N. Mulberry St., Hagerstown, Maryland.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (e) <b>Lobular pneumonia, bilateral</b> (b) <b>331X</b> DUE TO <b>cerebro-vascular accident</b> (c) <b>general arteriosclerosis</b> DUE TO <b>4 days</b> DUE TO <b>unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). (1) <b>Hypertension</b> (2) <b>Old cerebrovascular accident</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, if item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>3:30</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Western Maryland State Hospital, Hagerstown, Maryland</b> 20f. (City or town) (County) (State)	
21. I certify that (1) (the hospital) attended the deceased from <b>Nov. 16</b> , 19 <b>61</b> , to <b>Nov. 27</b> , 19 <b>61</b> , that (1) (we) last saw the deceased alive on <b>Nov. 27</b> , 19 <b>61</b> , and that death occurred at <b>3:30 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Victor L. Ramos, M.D.</b> 22c. PHYSICIAN'S NAME (Type) <b>VICTOR L. RAMOS, M.D.</b>		22b. DATE SIGNED <b>Nov. 27, 1961</b> 22d. ADDRESS <b>Western Maryland State Hospital, Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>11/30/61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>E.U.B. Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>Shenandoah, Page Co. Va.</b>		25a. REC'D BY REGISTRAR <b>NOV 29 1961</b> 25b. REGISTRAR'S SIGNATURE <b>Carroll S. Kenna</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown, Maryland.</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

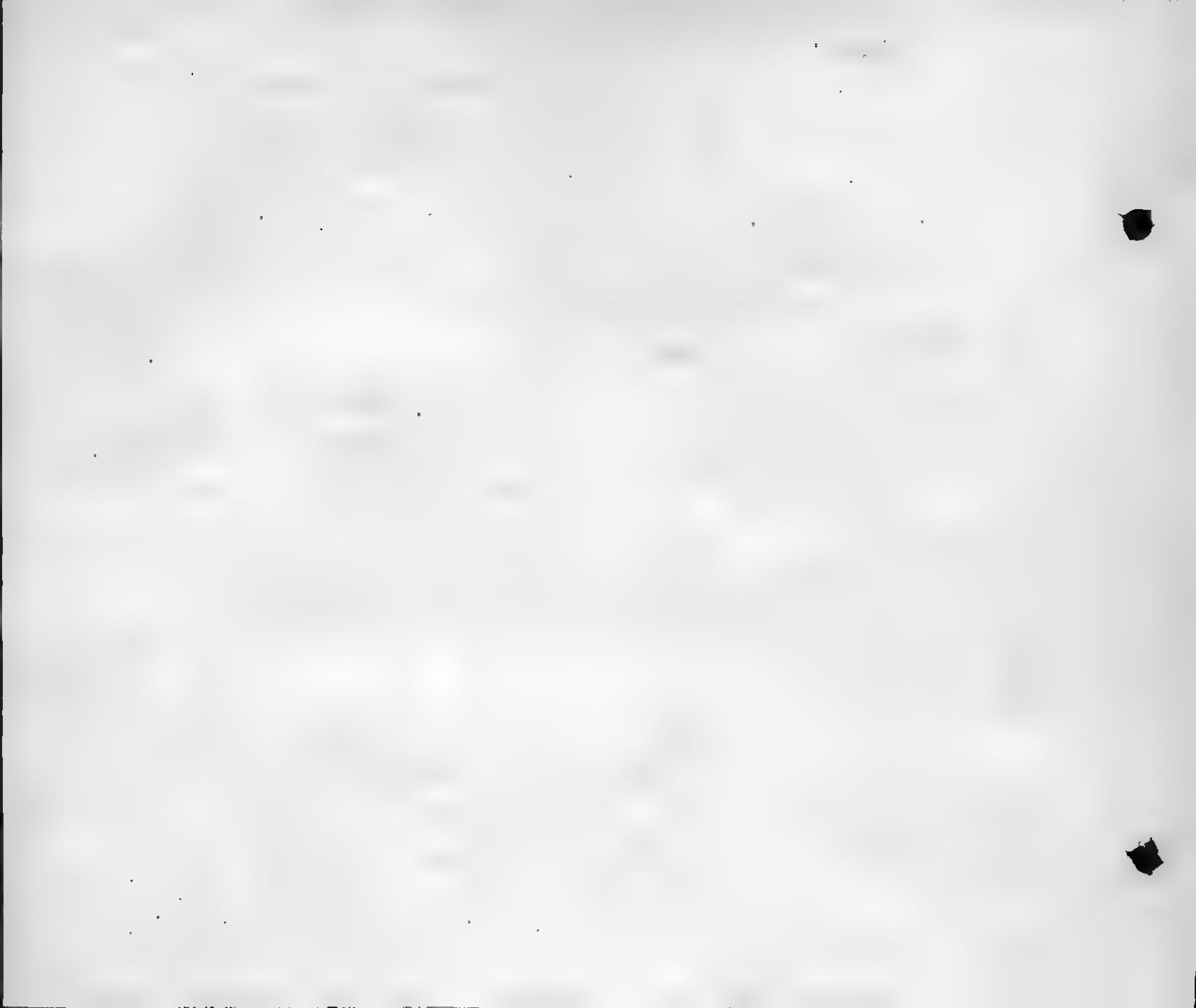
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13189

13174

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN <u>MD.</u> <u>60</u> <u>YES.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>328 S. POTOMAC ST.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> d. STREET ADDRESS <u>1328 S. POTOMAC ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LILLIE MAY NEIKIRK</u>		4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>18</u> Year <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>5/30/1880</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM HENRY ROHRER</u>		14. MOTHER'S MAIDEN NAME <u>MARY E. PUNK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MISS MARY GROUND</u>		Address <u>HAGERSTOWN MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Heart Vasc. Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arterio Sclerotic</u> (a), stating the underlying cause last. DUE TO (c) <u>Senility</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). <u>Senility</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED White Not White at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-1-61</u> to <u>11-18-61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>11-16-61</u> , and that death occurred at <u>3:30</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Dr. E. W. Fitts</u> M.D.		22b. DAY SIGNED <u>11/19/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. E. W. Fitts</u>		22d. ADDRESS <u>Hagerstown Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/20/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEM.</u>		23d. LOCATION (City, town or county) (State) <u>HAGERSTOWN MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Norman, Hagerstown Md.</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kline</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>NOV 21 '61</u>	



**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

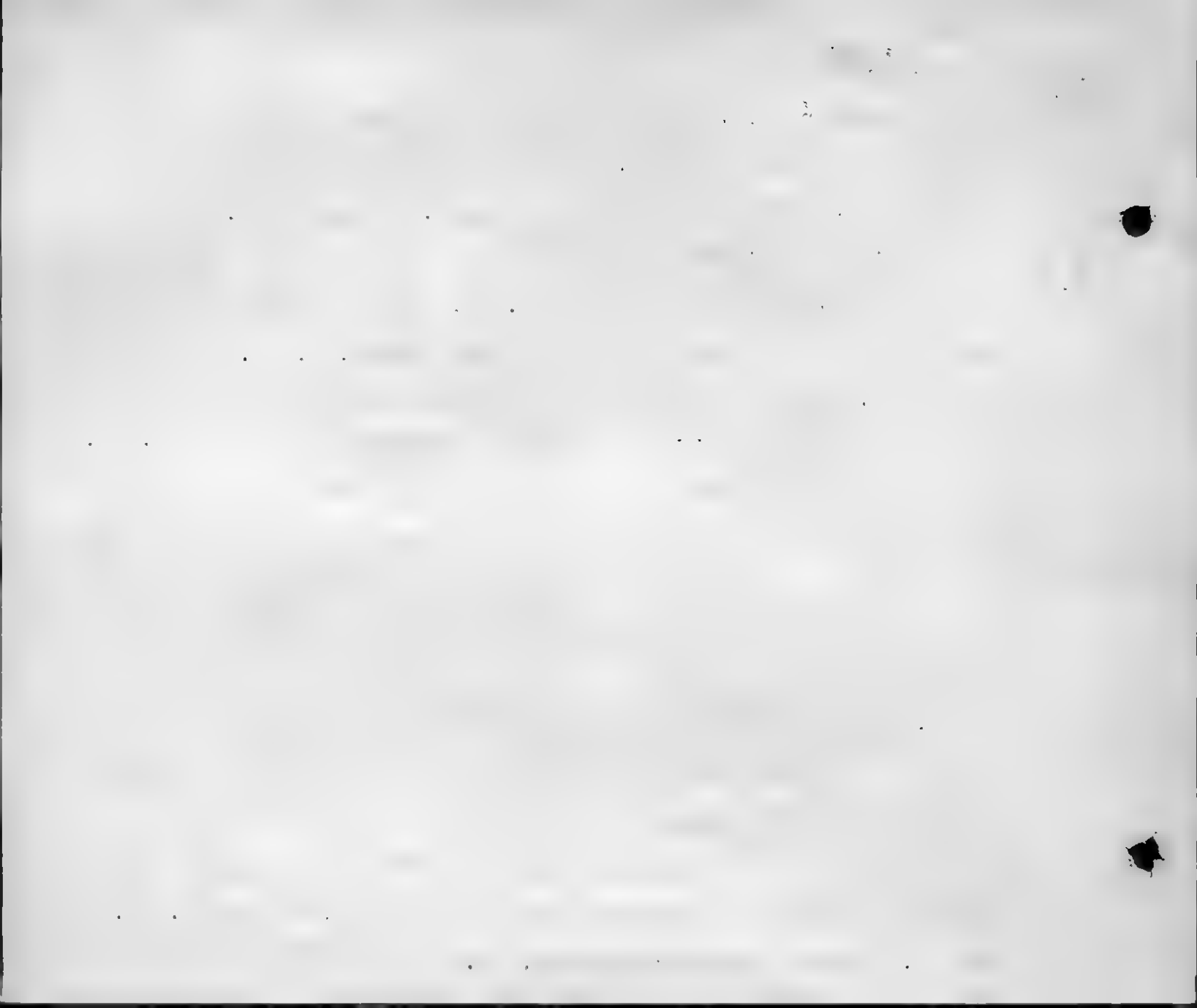
13190

## CERTIFICATE OF DEATH

13175

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admision) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b>		c. LENGTH OF STAY IN I <b>19 days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>3 Hagerstown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Avalon Manor Rest Home</b>		d. STREET ADDRESS <b>16 W. Magnolia Ave.</b>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Katie Virginia Osbourn</b>		4. DATE OF DEATH <b>November 27 19 61</b>		5. SEX <b>Female</b>	
6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 21, 1886</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Jefferson Co. W. Va.</b>	
13. FATHER'S NAME <b>Daniel H. Moler</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Staley</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>--</b>		16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT <b>Roger M. Osbourn</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriolar Nephrosclerosis</b> DUE TO (b) <b>Hypertensive vascular disease</b> DUE TO (c) <b>Arteriosclerosis - Generalized</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b> <b>5 yrs.</b> <b>5 yr.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Osteoarthritis - Generalized</b>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>---</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>	
20f. (City or town) <b>---</b>		20g. (County) <b>---</b>		20h. (State) <b>---</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 1, 1955</b> to <b>Nov. 27, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov. 27, 1961</b> , and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Lloyd A. Hoffmann</b>		22b. DATE SIGNED <b>11/29/61</b>		22c. PHYSICIAN'S NAME (Type) <b>Lloyd A. Hoffmann</b>	
22d. ADDRESS <b>214 N Potomac St Hagerstown, Md.</b>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22f. ATTENDING PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-30-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Elmwood Cemetery</b>	
23d. LOCATION (City, town or County) <b>Shepherdstown, W. Va.</b>		23e. (State) <b>---</b>		23f. (Country) <b>---</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		24a. ADDRESS <b>Hagerstown, Md.</b>		24b. REC'D BY REGISTRAR <b>DEC 1 '61</b>	
24c. REGISTRAR'S SIGNATURE <b>C. H. S. Kline</b>		24d. REGISTRAR'S SIGNATURE <b>---</b>		24e. REGISTRAR'S SIGNATURE <b>---</b>	

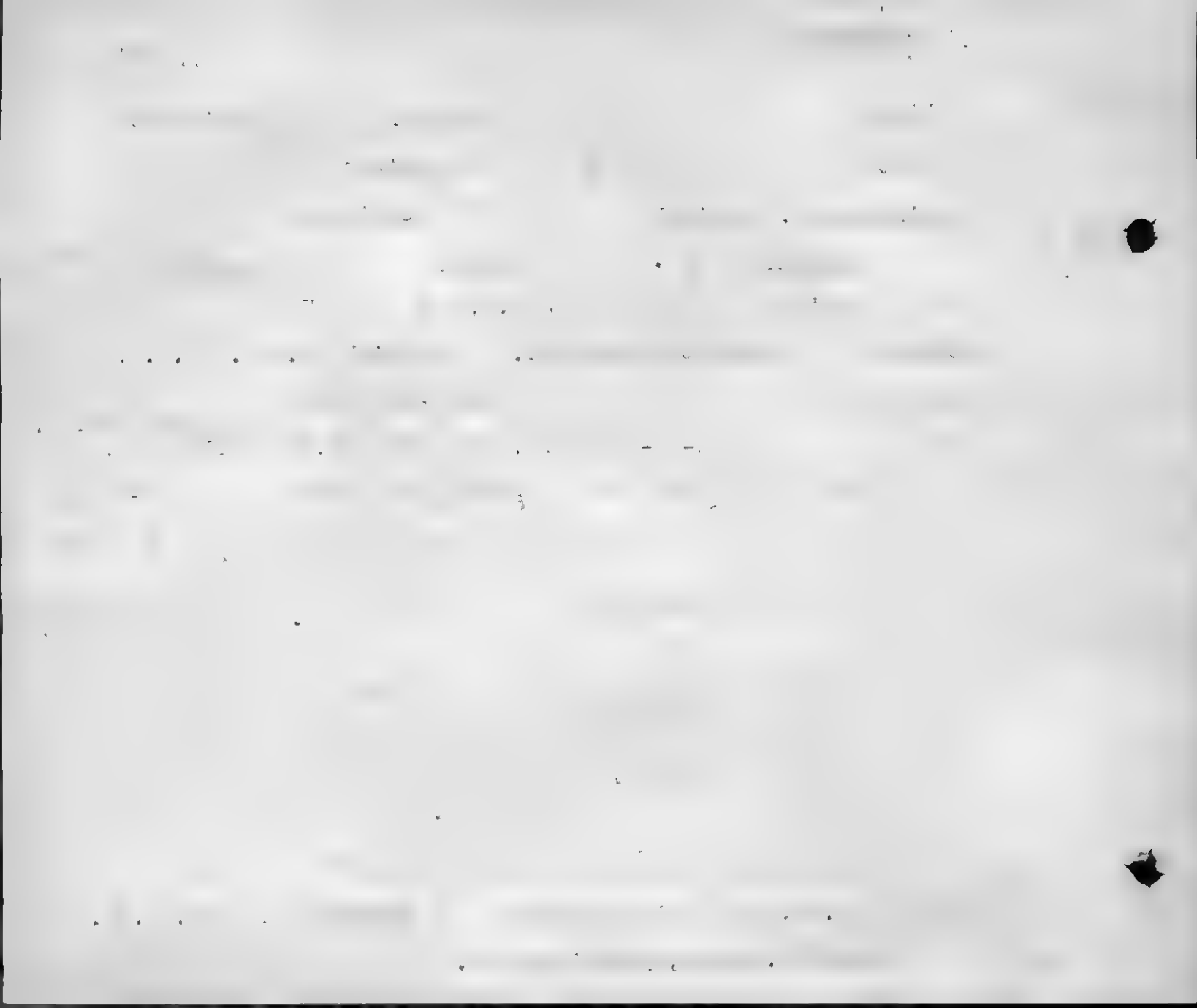
VR A15 (4)  
15M 9/60



## CERTIFICATE OF DEATH

13170

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN b. <b>5 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Co. Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before adm sion) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>8 Glenside Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ALBERT L. PALMER</b> 5. SEX <b>male</b> 6. COLOR OR RACE <b>white</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>Jan. 1, 1891</b> 9. AGE (In years, if UNDER 1 YEAR, last birthday) <b>70</b> yrs. Months Days Hours Min.		4. DATE OF DEATH <b>November 17, 1961</b> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>shoemaker</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Hagerstown Shoe Co.</b> 11. BIRTHPLACE County & State or foreign country <b>Frederick Co. Md.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Elmer Palmer</b> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> 16. SOCIAL SECURITY NO. <b>214-09-5764</b> 17. INFORMANT <b>Mrs. Nannie Palmer</b> Address <b>Hagerstown, Md.</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Jane Moser</b> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>Arterio Sclerosis (concl)</b> DUE TO (b) <b>Myasthenia Gravis</b> DUE TO (c) <b>10 yrs.</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) <b>Myasthenia Gravis</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) County State	
21. I certify that I (this hospital) attended the deceased from <b>Nov 12, 1961</b> to <b>Nov 17, 1961</b> , that I (we) last saw the deceased alive on <b>Nov 17, 1961</b> , and that death occurred at <b>10:00 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>JH Beachley M.D.</b> 22c. PHYSICIAN'S NAME (Type) <b>JH Beachley</b>		22b. DATE SIGNED <b>Nov 17, 1961</b> 22d. ADDRESS <b>Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>Nov. 20, 1961</b> 23c. NAME OF CEMETERY OR CREMATORY <b>United Brethern</b> 23d. LOCATION City, town or county State <b>Myersville, Fred. Co. Md.</b>		25a. REC'D BY REGISTRAR <b>Paul F. Bittle</b> 25b. REGISTRAR'S SIGNATURE <b>Paul F. Bittle</b> DATE <b>NOV 21 '61</b>	



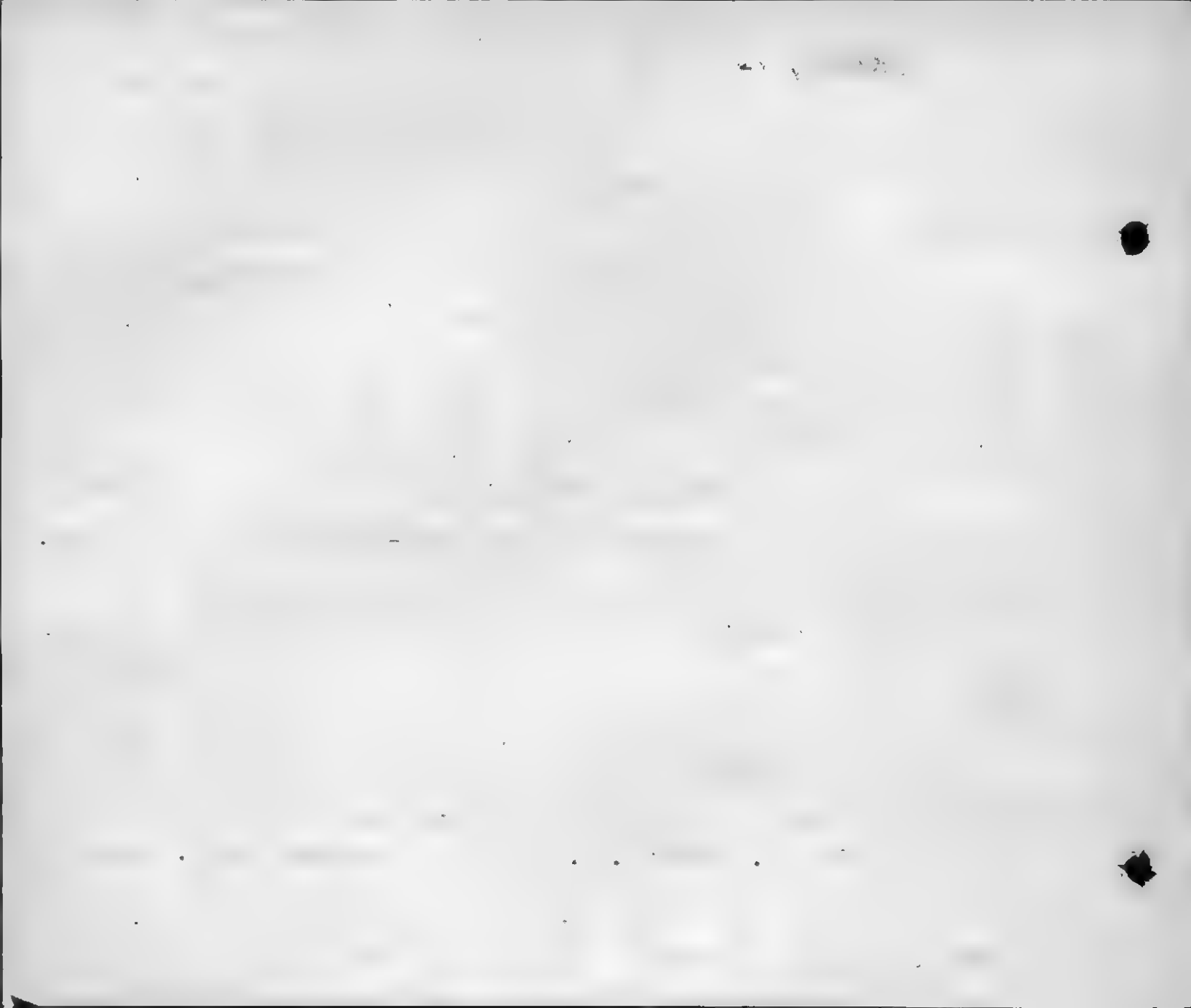
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
TSM 7, 61

M

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
13192		14541	
1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS X	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 4 DAYS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASH. CO. HOSPITAL		f. DATE OF DEATH NOVEMBER 30 1961	
3. NAME OF DECEASED (Type or print) SOPHIA T. POFFENBERGER		Month Day Year	
5. SEX FEMALE		9. AGE (In years IF UNDER 1 YEAR last birthday) Months Days Hours Min.	
6. COLOR OR RACE WHITE		B DATE OF BIRTH FEBRUARY 11 1885 76 yrs 7 19	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED TELEPHONE OPERATOR - C & P TEL CO NEAR BAKERSVILLE WASH. CO. MD. U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED TELEPHONE OPERATOR - C & P TEL CO NEAR BAKERSVILLE WASH. CO. MD. U.S.A.		11. BIRTHPLACE (County & State, or foreign country) MARY ANN LINE	
13. FATHER'S NAME CHRISTIAN M. POFFENBERGER		14. MOTHER'S MAIDEN NAME MARY ANN LINE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO		16. SOCIAL SECURITY NO. 213-69-8541	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO Arteriosclerotic cardio-vascular disease 10 Yrs.		INTERVAL BETWEEN ONSET AND DEATH instant	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lobar pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1957 to 11/30/61, that (I) (we) last saw the deceased alive on 11/29/61, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE Walter H. Shealy M.D.		22b. DATE SIGNED 12/2/61	
22c. PHYSICIAN'S NAME (Type) Walter H. Shealy M.D.		22d. ADDRESS Sharpsburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC 3, 1961	
23c. NAME OF CEMETERY OR CREMATORY BAKERSVILLE CEMETERY		23d. LOCATION (City, town or county) (State) BAKERSVILLE WASH. CO. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John H. Baer		25a. REC'D BY REGISTRAR DATE DEC 3 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

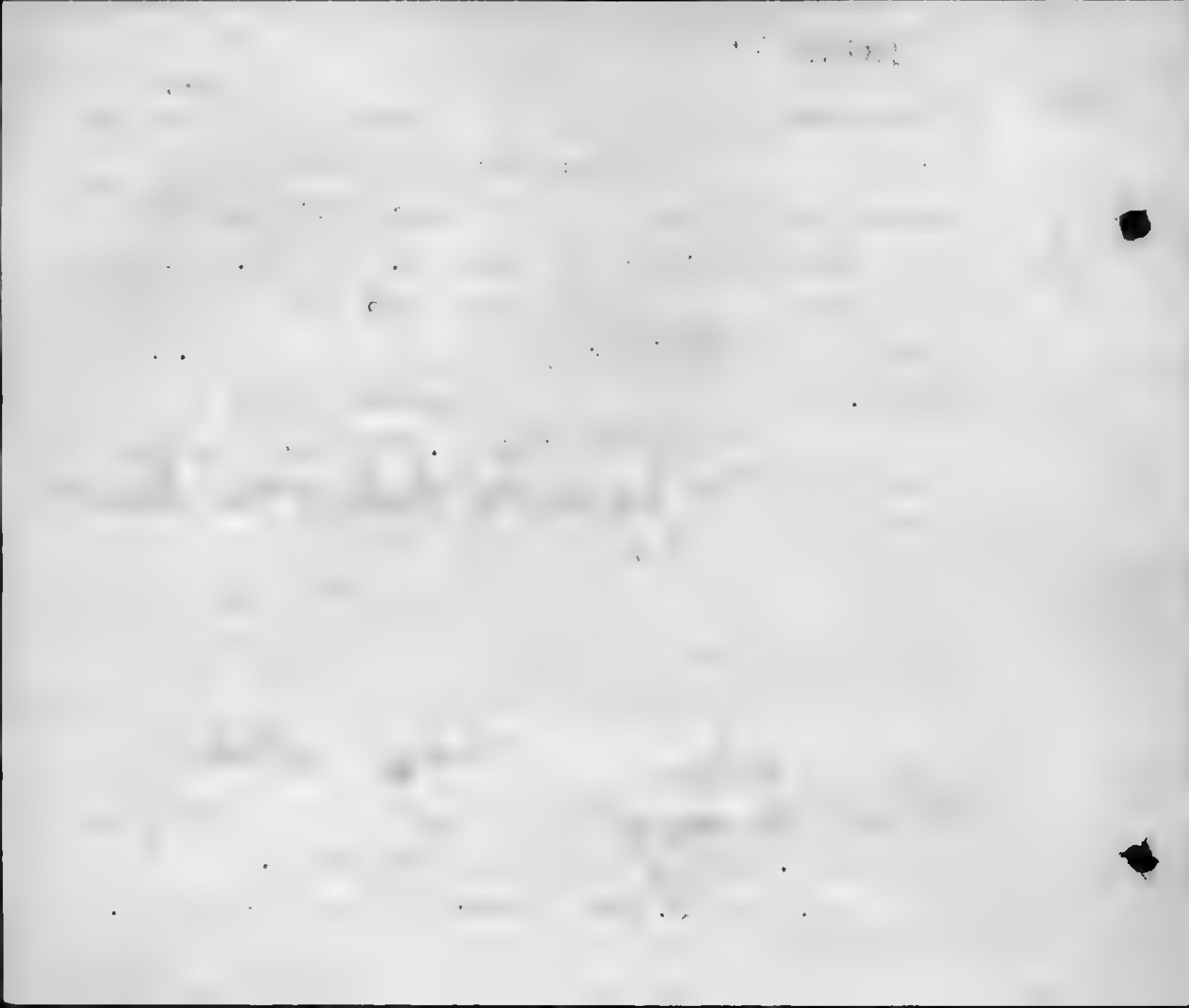


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN b <b>10 minutes</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if not usual residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Williamsport RFD #2</b> d. STREET ADDRESS <b>Pinesburg Williamsport RFD #2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William Richardson Potts Sr.</b> 4. DATE OF DEATH <b>Nov. 16 19 61</b>		5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>July 16 1899</b> 9. AGE (In years last birthday) <b>62</b> yrs. <b>4</b> Months <b>0</b> Days <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attendant</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Western Md. State Hospital</b> 11. BIRTHPLACE (Country, State, or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>George W. Potts</b> 14. MOTHER'S MAIDEN NAME <b>Elizabeth R Harsh</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> 16. SOCIAL SECURITY NO. <b>215 09 7358</b> 17. INFORMANT <b>William R. Potts</b> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Ac myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Immediate</b> DUE TO (c) <b>Immediate</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/16/61</b> to <b>11/16/61</b> , that (I) (we) last saw the deceased alive on <b>11/16/61</b> , and that death occurred at <b>11/16/61</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Ralph F. Young</b> 22c. PHYSICIAN'S NAME (Type) <b>Ralph F. Young</b>		22b. DATE SIGNED <b>11/17/61</b> 22d. ADDRESS <b>Williamsport Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>Nov. 20-61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>Near Clearspring Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 20 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur E. Evans</b>	

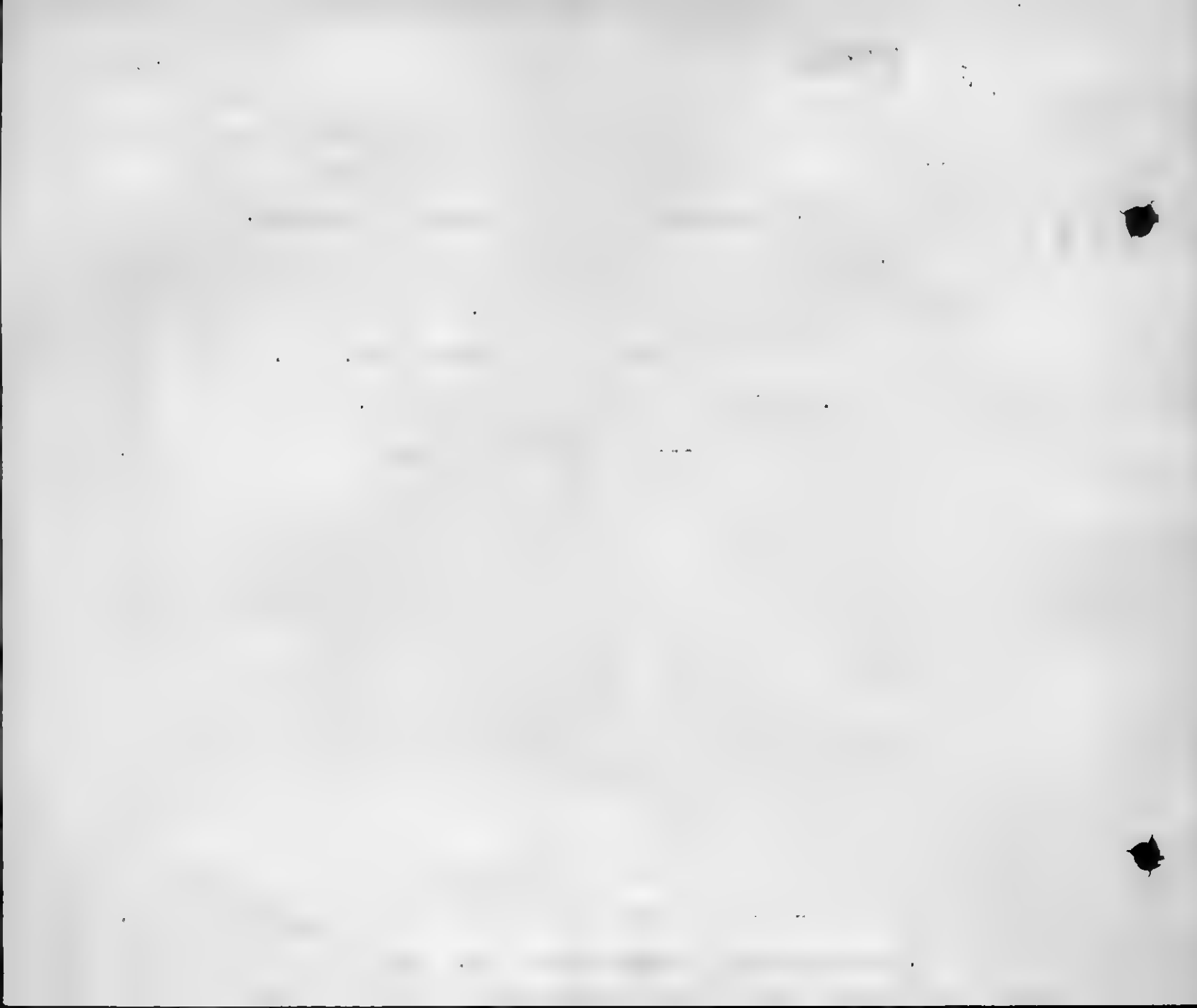


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13194 CERTIFICATE OF DEATH 13178											
1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>2023 Virginia Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Elizabeth Ann Rhoades</b>						4. DATE OF DEATH <b>November 27 1961</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>May 8, 1927</b>		9. AGE (In years last birthday) <b>34</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Crist W. Fuller</b>						14. MOTHER'S MAIDEN NAME <b>Grace V. Seibert</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>----</b>						16. SOCIAL SECURITY NO. <b>Charles Fuller Hagerstown, Md.</b>					
17. INFORMANT <b>Charles Fuller Hagerstown, Md.</b>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia Bilateral</b> DUE TO (b) <b>Heart Failure</b> DUE TO (c) <b>Pulmonary Congestion &amp; Edema</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
INTERVAL BETWEEN ONSET AND DEATH <b>12 yrs</b> <b>3 mo</b> <b>2 wk</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 1 - 66</b> to <b>Oct 27, 1961</b> , that (I) (we) last saw the deceased alive on <b>Oct 24, 1961</b> , and that death occurred at <b>11:00 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>[Signature]</b>						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <b>Dr. E. W. J. [Signature]</b>						22d. ADDRESS <b>Hagerstown, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-30-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Hagerstown, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>						25a. REC'D BY REGISTRAR <b>Arthur S. [Signature]</b> 25b. REGISTRAR'S SIGNATURE DATE <b>DEC 1 '61</b>					



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

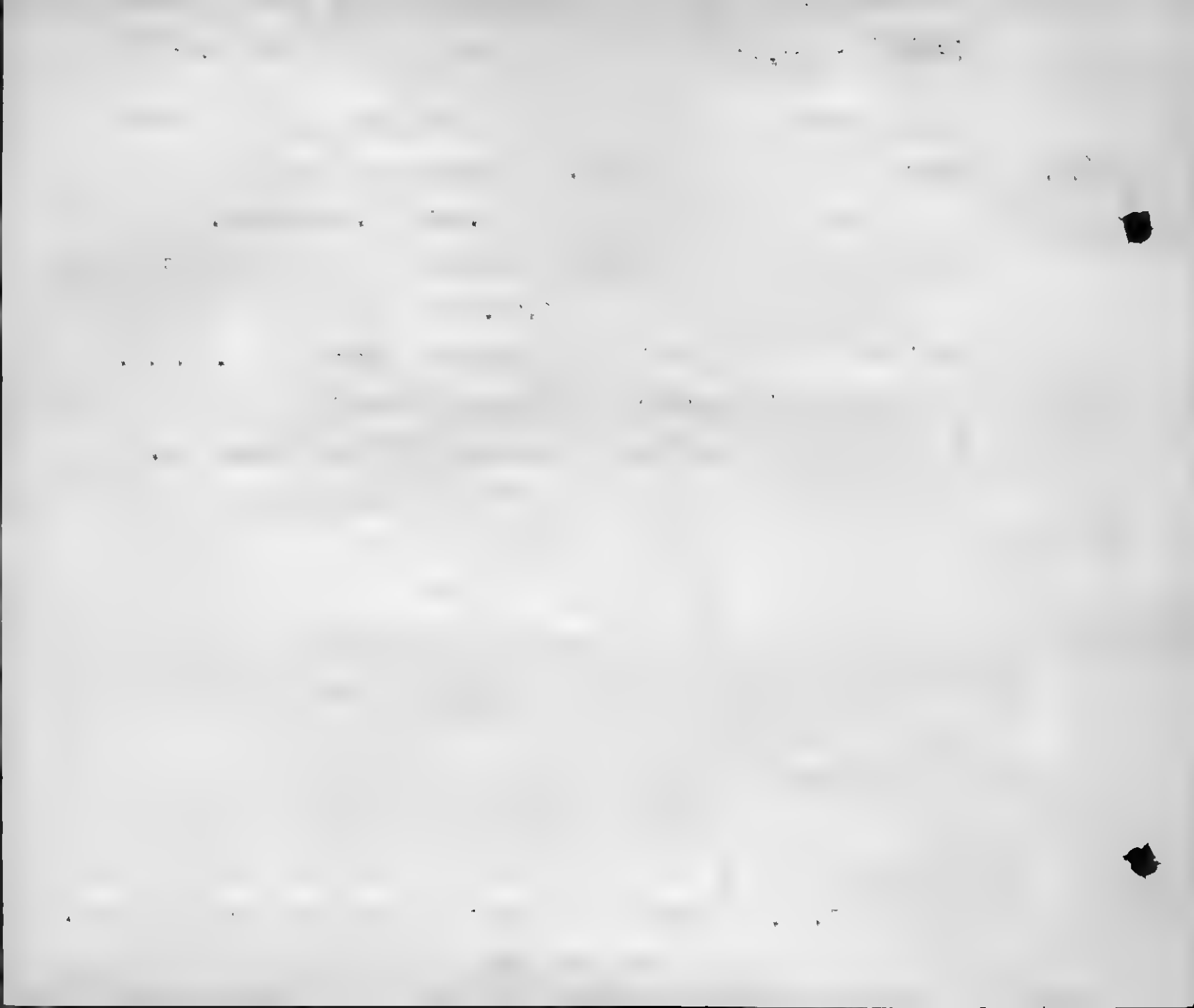
13195  
MAYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13128

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <b>Hancock</b> c. LENGTH OF STAY IN 1b <b>50 Yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <b>Hancock</b> d. STREET ADDRESS <b>W. Main St. Hancock Md.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Iva Belle Rhodes</b>		4. DATE OF DEATH <b>11 11 19 61</b>	
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3.28.1880</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Somerset County Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Andrew Fleissachhauer</b>		14. MOTHER'S MAIDEN NAME <b>Mary E Griffith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs Bertha Heller Hancock Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Citrus Melancholia</b> DUE TO <b>Heart</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Malnutrition</b> DUE TO <b>Malnutrition</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Confined to wheel chair for years</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>A. E. Cuthbert</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Arthur E. Cuthbert</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>11/14/61</b>	
Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11.14.61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hopewell Methodist</b>		22d. LOCATION (City, town, or country) (State) <b>Hopewell Somerset Penna.</b>	
23. FUNERAL DIRECTOR <b>Howard J. Stone Hancock Md</b>		24a. REC'D BY REGISTRAR <b>NOV 14 '61</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

M

I

MEDICAL CERTIFICATION



1  
FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a day is necessary, please excuse the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

13196  
13180  
MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>1 month</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Maryland State Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <u>Frederick</u> d. STREET ADDRESS <u>68 Lincoln Apt</u>	
3. NAME OF DECEASED (Type or print) <u>Howard Henry ROBINSON</u>		4. DATE OF DEATH Month <u>11</u> Day <u>10</u> Year <u>1961</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-9-1892</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractors Helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fred Brick wks</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13. FATHER'S NAME <u>Henry Robinson</u>		14. MOTHER'S MAIDEN NAME <u>Luvenia Robinson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-10-5534</u>	
17. INFORMANT <u>Lucy Doozie Robinson</u>		Address <u>68 Lincoln</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b) <u>Fractured Femur Rt.</u> (c) <u>3 mo</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>Chronic of Lung &amp; Chronic Rheumatoid Arthritis</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Fell on floor</u>	
20c. TIME OF INJURY Month <u>Aug</u> Day <u>15</u> Year <u>1961</u>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20e. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20f. (City or town) <u>Frederick</u> (County) <u>Frederick</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural Causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>A. E. Hicks</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A. E. Hicks</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-13-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>		22d. LOCATION (City, town, or country) <u>Frederick</u> (State) <u>Maryland</u>	
23. FUNERAL DIRECTOR <u>C.E. Hicks, III</u>		ADDRESS <u>Frederick, Md</u>	
24a. REC'D BY REGISTRAR <u>NOV 14 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

DATE SIGNED  
11/10/61



may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13197

13181

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>60 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Addie Simmons Roe</b>		4. DATE OF DEATH Month Day Year <b>November 14 19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 19, 1881</b>
9. AGE (In years last birthday) yrs. <b>80</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attendant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Day Nursery</b>	
11. BIRTHPLACE (State or foreign country) <b>Crompton, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Frank Simmons</b>		14. MOTHER'S MAIDEN NAME <b>Matilda Waddell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>--</b>		16. SOCIAL SECURITY NO. <b>220-30-8814</b>	
17. INFORMANT <b>Webster Fugate</b>		Address <b>Benton Harbor, Mich.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease -</b>			
420.0 DUE TO <b>Generalized arteriosclerosis -</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b>			
DUE TO (c) <b>Myocardial - Rt. Ventricle - back -</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>years.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic heart disease</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell in back yard</b>	
20c. TIME OF INJURY Month, Day, Year Hour 0 m. <b>12 Mid.</b> 19 <b>61</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Hagerstown Wash. Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 13 1961</b> to <b>Nov. 14 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov. 13 1961</b> , and that death occurred at <b>3:20 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Philip J. Hirshman</b>		22b. ADDRESS <b>159 W. Washington St. Hagerstown, Maryland</b>	
22c. PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>		22d. ADDRESS <b>159 W. Washington St. Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-16-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		25a. REC'D BY REGISTRAR <b>NOV 17 '61</b>	
ADDRESS <b>Hagerstown, md.</b>		25b. REGISTRAR'S SIGNATURE <b>C. H. S. H. H. H.</b>	

M

91

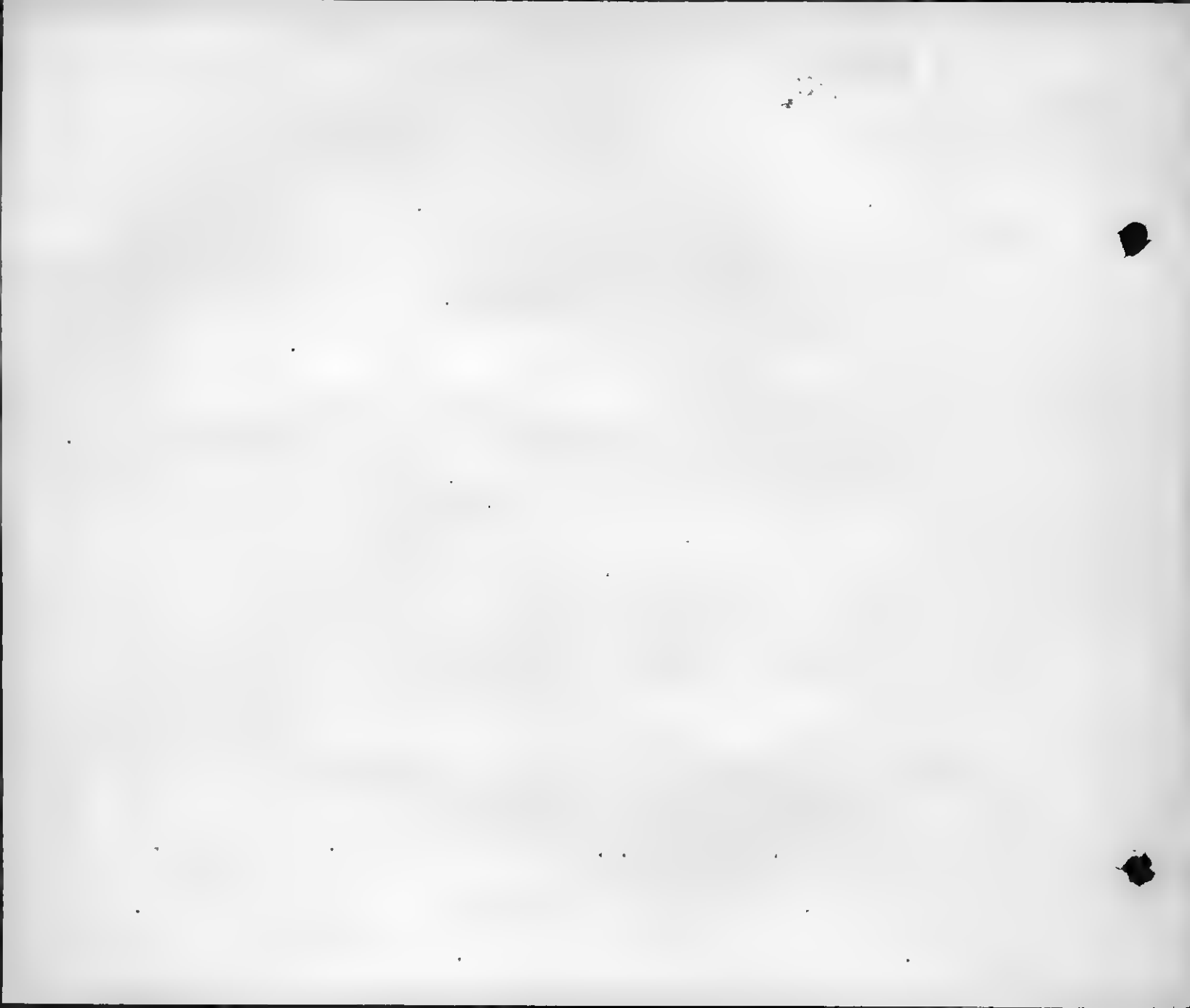
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13198

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

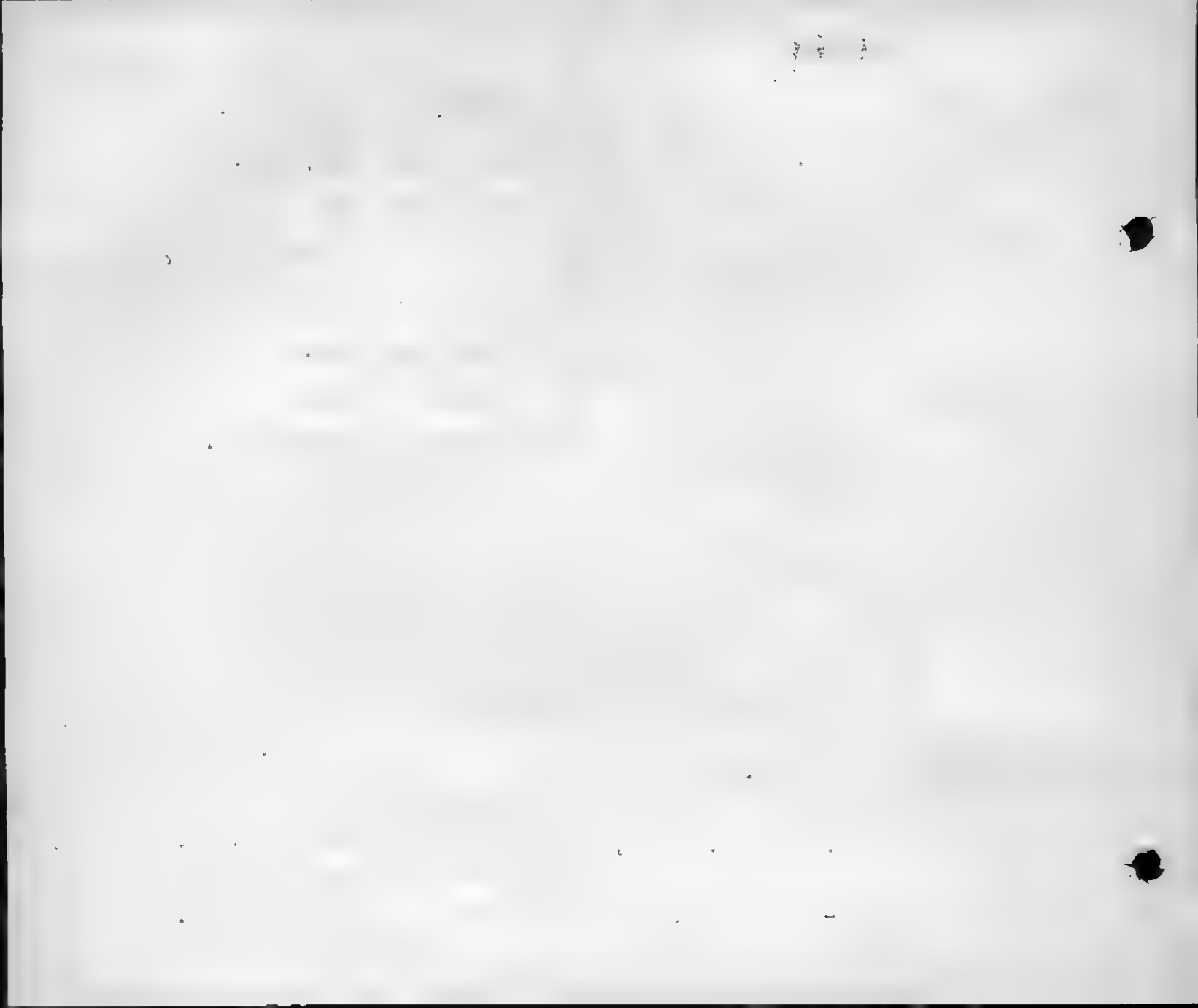
13182

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Maryland.</b> 13	
c. LENGTH OF STAY IN 1b <b>life time</b>		d. STREET ADDRESS <b>409 Suman Ave.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>409 Suman Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Dianne</b> First <b>(None)</b> Middle <b>Russ</b> Last	4. DATE OF DEATH <b>Nov</b> Month <b>8</b> Day <b>19</b> Year <b>61</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 26 1950</b>
9. AGE (In years lost birthday) <b>11</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b> Hours <b>11</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Russ</b>		14. MOTHER'S MAIDEN NAME <b>Nettie Burnett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(if yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Nettie Russ</b>		Address <b>409 Suman Ave.</b>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>aspiration pneumonitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Microcephalia</b> DUE TO (c) <b>1</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>  <b>10 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>None</b>	
20c TIME OF INJURY Month, Day, Year Hour o. m. <b>None</b> 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <b>July 31</b> 19 <b>61</b> to <b>Nov. 8</b> 19 <b>61</b> that (I) (we) last saw the deceased alive on <b>Oct. 18</b> 19 <b>61</b> and that death occurred at <b>7 1/2</b> M. from the causes and on the date stated above.			
22a SIGNATURE <b>Harold R. Tritch, Jr</b> M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 11-9-61 22b DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Harold R. Tritch, Jr MD</b>		22d. ADDRESS <b>302 N. Potomac Street -Hagerstown, Md</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>11-10-1961</b>	23c NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>
24 FUNERAL DIRECTOR'S SIGNATURE <b>John R Watson Jr. Hagerstown Md.</b>		25a REC'D BY REGISTRAR <b>NOV 14 '61</b> DATE 25b REGISTRAR'S SIGNATURE <b>Wm. S. Smith</b>	

M

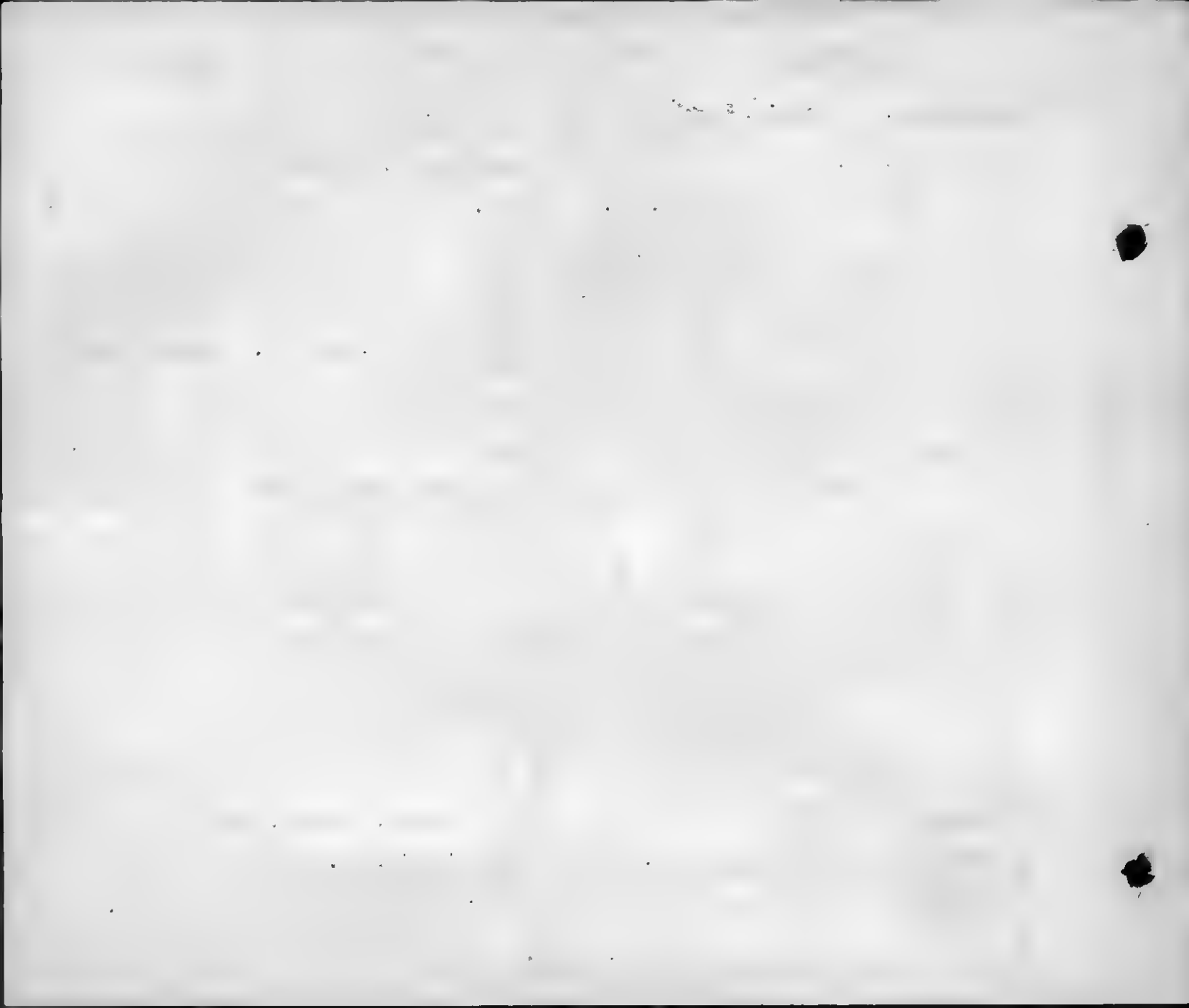
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 306 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
13199 CERTIFICATE OF DEATH Reg. 13183											
1. PLACE OF DEATH a. COUNTY <b>Washington, Ft Ritchie, Cascade MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington Allegany</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft Ritchie, Md.</b>						c. LENGTH OF STAY IN 1b <b>Fort Ritchie, Maryland/ Cumberland</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>US Army Dispensary, Ft Ritchie, Md.</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>Raymond Lionel Schanholtz</b>						4. DATE OF DEATH Month Day Year <b>Nov 28 19 61</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cau</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>28 Aug 1914</b>		9. AGE (In years lost birthday) yrs <b>47</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>2 1/2 20 41</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>US Army</b>		11. BIRTHPLACE (State or foreign country) <b>Green Spring, West Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
13. FATHER'S NAME <b>Herbert R Schanholtz</b>						14. MOTHER'S MAIDEN NAME <b>Deceased</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>to present</b>		17. INFORMANT <b>From Army Records by WILLIAM T CUZICK, Capt, MSC</b>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cause of death unknown pending result of 775.5</b> DUE TO <b>Toxicologic examination</b>											
(b) <b>Respiratory failure secondary to cerebral depression</b>											
(c) <b>of unknown etiology. (Autopsy report)</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <b>28 November 19 61</b> , and that death occurred at <b>4:50 P.M.</b> , from the causes and on the date stated above.											
ACTUAL SIGNATURE <b>Patrick J. Ferraro Capt MC</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>M.D. Fort Ritchie, Cascade, Maryland 28 Nov 61</b>							
PHYSICIAN'S NAME (Type) <b>PATRICK J FERRARO, CAPT., MC</b>				Fort Ritchie, Md. US Army Dispensary							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/2/1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Lawn Memorial Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Marlin Roe</b>				ADDRESS <b>Waynesboro, Penna.</b>		24a. REC'D BY REGISTRAR <b>DEC 4 '61</b>		24b. REGISTRAR'S SIGNATURE <b>C. L. H. H. H.</b>			

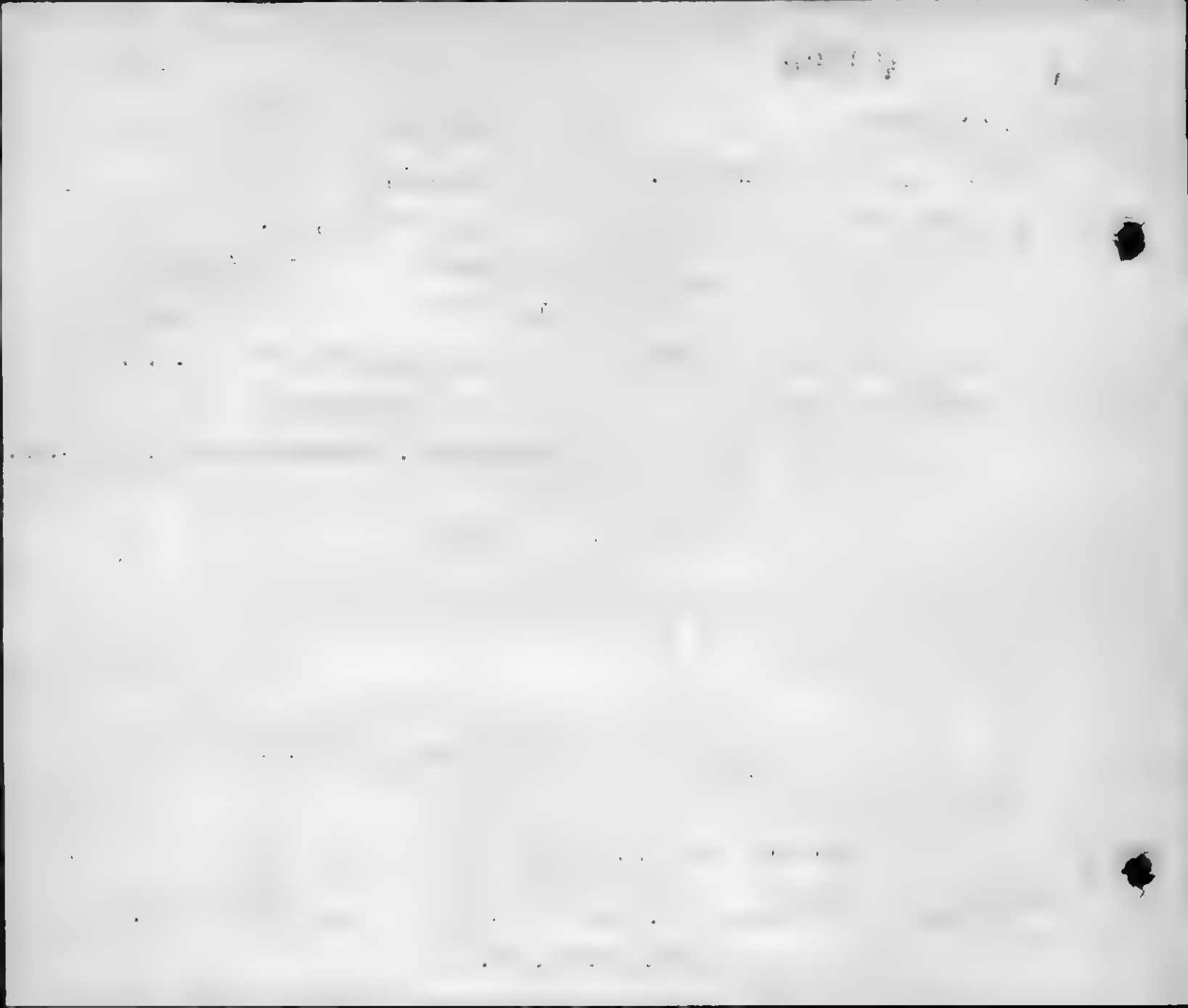


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 7 61

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
13200  
CERTIFICATE OF DEATH  
13184

<b>1. PLACE OF DEATH</b> a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL 1, CLEAR SPRING, MD.</u> <u>LIFE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL 1,</u> d. STREET ADDRESS <u>CLEAR SPRING, MD.</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>FRANK OWEN SEIBERT</u> First Middle Last <b>4. DATE OF DEATH</b> <u>11/6/1961</u> 19 Month Day Year		<b>5. SEX</b> <u>MALE</u> <b>6. COLOR OR RACE</b> <u>WHITE</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>8. DATE OF BIRTH</b> <u>1/10/1872</u> <b>9. AGE</b> (In years last birthday) <u>89</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>9</u> Days <u>26</u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>FARMING</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>WASHINGTON COUNTY U.S.A.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>CHARLES SEIBERT</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>ELIZEBETH FOUCHE</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>  </u> <b>16. SOCIAL SECURITY NO.</b> <u>  </u> <b>17. INFORMANT</b> <u>FRANKLIN S. SEIBERT, ROUTE 1, CLSPG. MD.</u> (If yes, give name and date of service)	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC MYOCARDITIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>unknown</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u> <b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Dec. 15, 1960</u> , 19 <u>  </u> , to <u>Nov. 6, 1961</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>Nov. 2, 1961</u> , 19 <u>  </u> , and that death occurred at <u>9:15 AM</u> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>Archie Robert Cohen</u> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Archie Robert Cohen, M.D.</u>		<b>22b. DATE SIGNED</b> <u>11/07/61</u> <b>22d. ADDRESS</b> <u>Clear Spring, Maryland</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u> <b>23b. DATE THEREOF</b> <u>11/8/1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>ST. PAULS CEMETERY</u> <b>23d. LOCATION</b> (City, town or county) (State) <u>WESTERN PIKE, MD.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Margaret R. Rowland</u> <b>24b. ADDRESS</b> <u>CLEAR SPRING, MD.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>Arthur S. Kraus</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>  </u> <b>DATE</b> <u>NOV 9 '61</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

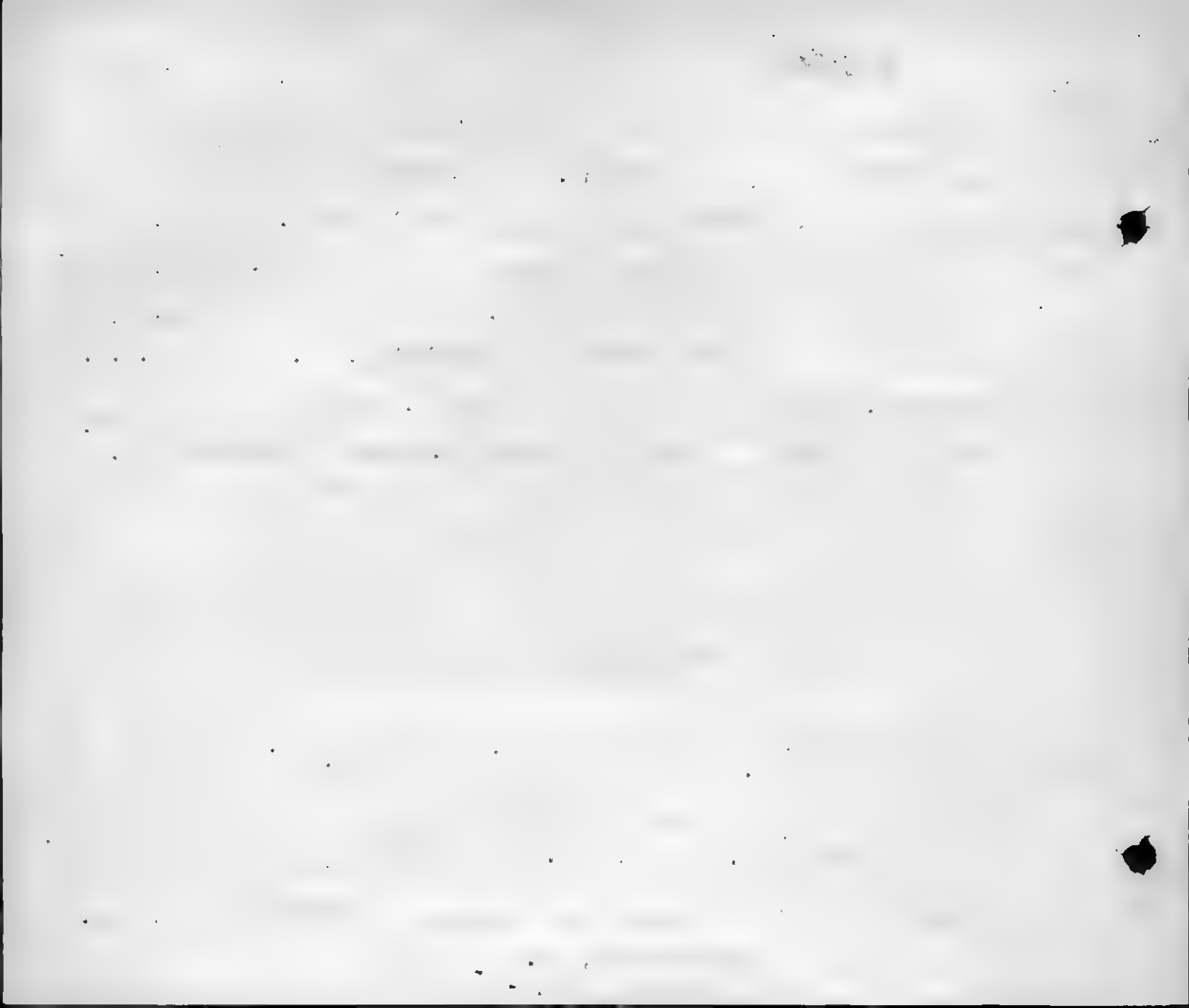
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13201

## CERTIFICATE OF DEATH

13185

<b>1. PLACE OF DEATH</b> a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>11 Hrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON CO. HOSPITAL</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>232 BELL VUE AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>NELLIE</b> 4. DATE OF DEATH <b>NOV. 14 19 61</b>		5. SEX <b>FEMALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>SEPT. 10, 1910</b> 9. AGE (in years last birthday) <b>51 yrs.</b> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WORK</b> 11. BIRTHPLACE (County & State, or foreign country) <b>FRONT ROYAL, VA.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>WILBUR H. CAMERON</b> 14. MOTHER'S MAIDEN NAME <b>EDITH M. SIMONS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b> 16. SOCIAL SECURITY NO. <b>NONE</b> 17. INFORMANT <b>RAYMOND E. SHANK</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>241X</b> DUE TO Acute Dilatation, right ventricle Conditions, if any, which gave rise to immediate cause (b) <b>241X</b> DUE TO Pulmonary Emphysema (a), stating the underlying cause last. Bronchial Asthma PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 1/2 hours</b> <b>18 months</b> <b>18 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) <b>W. T. Layman</b> attended the deceased from <b>Nov. 14 11:00 pm.</b> to <b>Nov. 14 1961</b> , that (I) <b>(X)</b> last saw the deceased alive on <b>Nov. 14 1961</b> , and that death occurred at <b>11:00 pm.</b> from the causes and on the date stated above. 22a. SIGNATURE <b>W. T. Layman</b> 22b. DATE SIGNED <b>11-15-61</b> 22c. ADDRESS <b>100 Professional Arts Bldg.</b> <b>Hagerstown, Maryland</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 23b. DATE THEREOF <b>11/17/61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>SHANKTOWN CEMETERY</b> 23d. LOCATION (City, town or county) <b>SHANKTOWN MD.</b> 23e. REC'D BY REGISTRAR <b>NOV 21 '61</b> 23f. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be filled in by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 41  
ISM 7 61

# MARYLAND STATE DEPARTMENT OF HEALTH

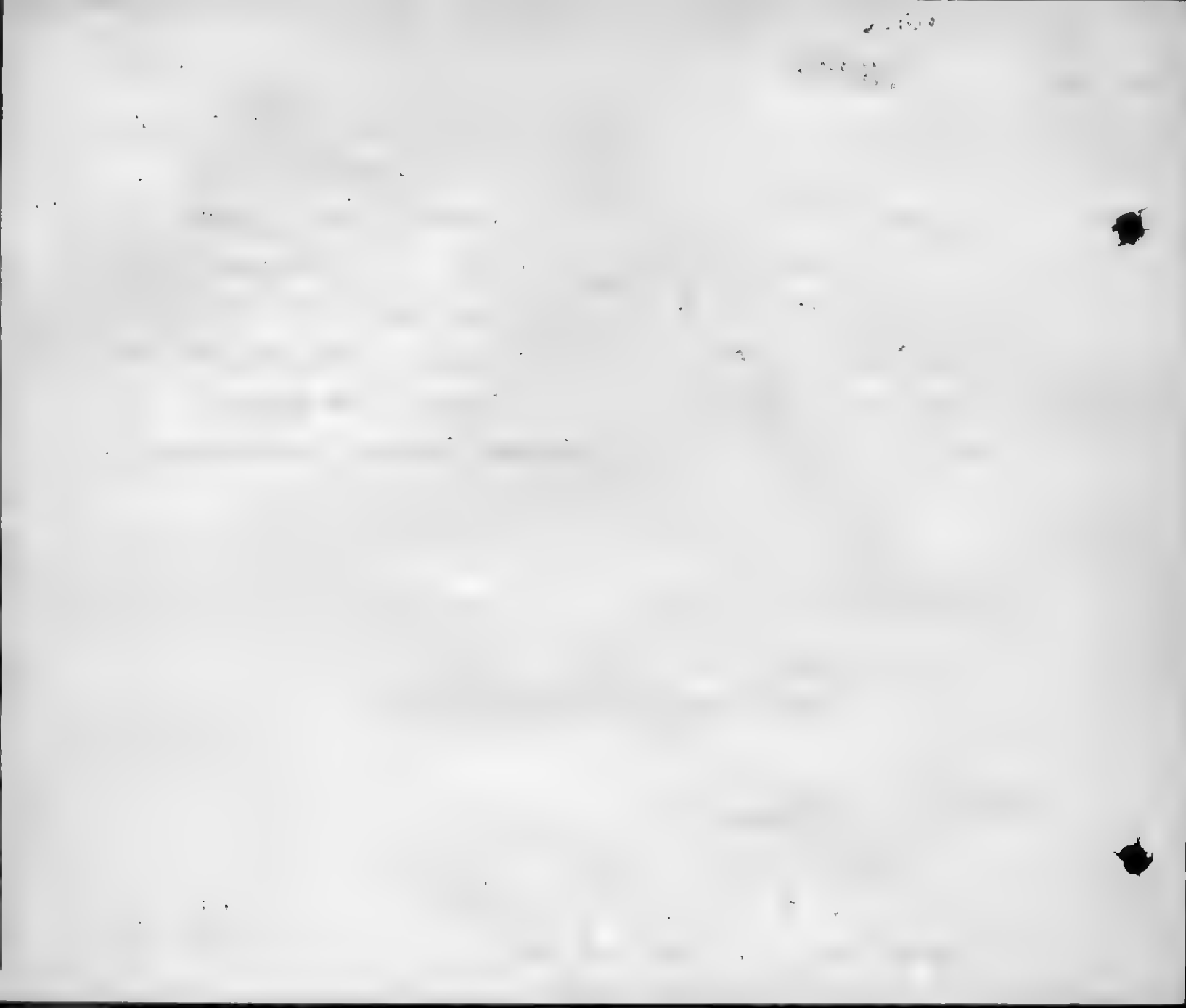
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13202

1318C

<b>1. PLACE OF DEATH</b> a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN TB <u>19 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH. Co. Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> d. STREET ADDRESS <u>116 NORTH CANNON AVENUE</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>HARRY L. SHEPLEY</u>		<b>4. DATE OF DEATH</b> <u>NOVEMBER 7 - 1961</u>	
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>APRIL 30, 1888</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>RETIRED COSTODIAN</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>FRED. CO. MD.</u>	
<b>13. FATHER'S NAME</b> <u>JOHN C. SHEPLEY</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>SUSAN GROSSNICKLE</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>217-10 3160</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Active chronic valvular disease</u> (c) <u>5 yrs</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>
<b>21. I certify that (I) (th) (s) hospital) attended the deceased from <u>Nov 7 - 1961</u>, to <u>Nov 7 - 1961</u>, that (I) (we) last saw the deceased alive on <u>Nov 7 - 1961</u>, and that death occurred <u>Nov 7 - 1961</u>, from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>S. E. W. Dittus</u>		<b>22b. DATE SIGNED</b> <u>Nov 7 - 1961</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Dr. E. W. Dittus Jr.</u>		<b>22d. ADDRESS</b> <u>Hagerstown Md</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>Nov. 9, 1961</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>FAIRVIEW CEMETERY</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>KEEDYSVILLE WASH. CO. MD.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John D. Bast</u>		<b>25a. REC'D BY REGISTRAR</b> <u>NOV 13 1961</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur J. Frank</u>			



FOR STATE  
HEALTH DEPT.

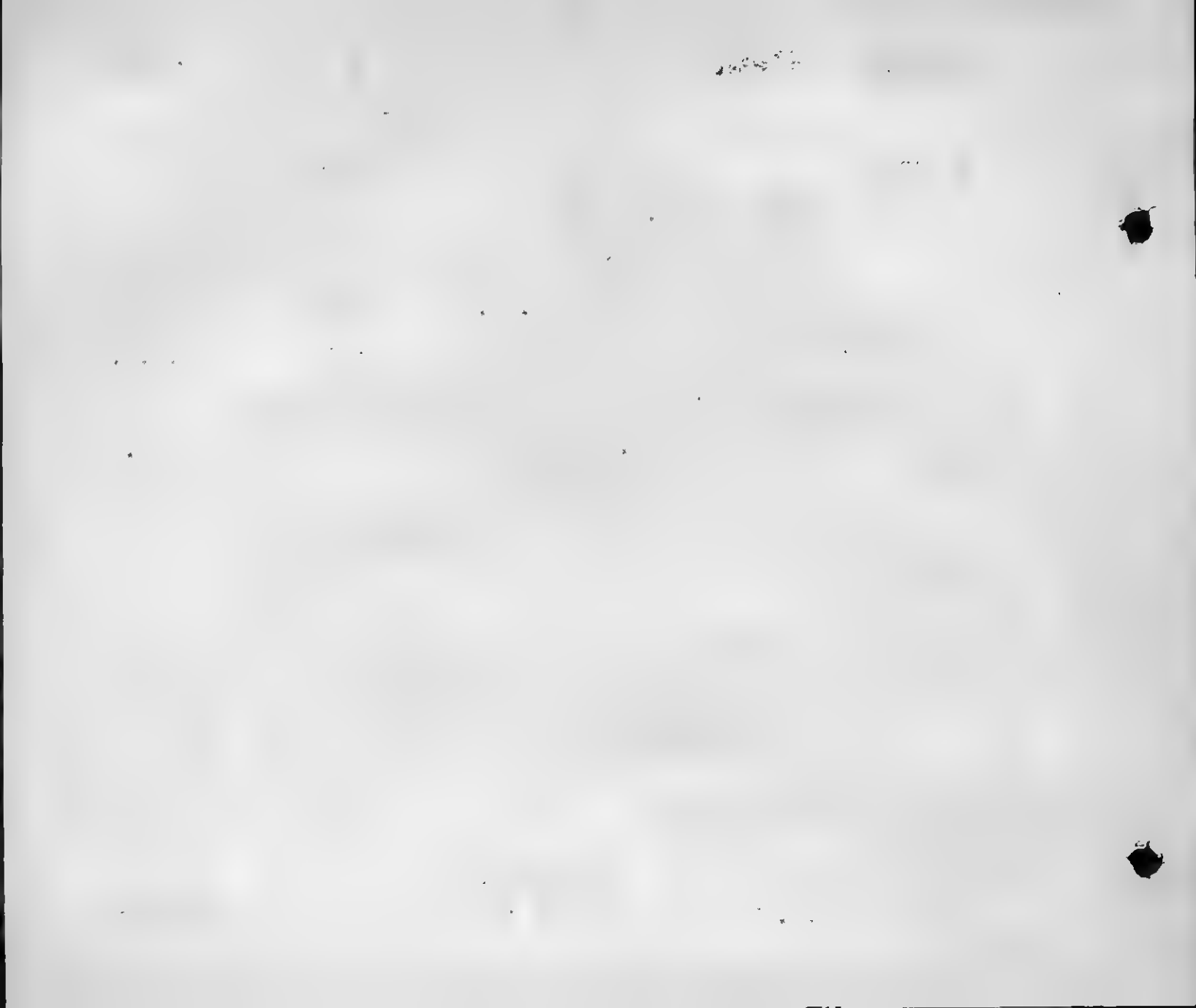
TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

13203

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 13187

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hancock</b> c. LENGTH OF STAY IN <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Route 522 in Corp. limits</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hancock Maryland</b> d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) <b>Roscoe Quincy Shives</b>		4. DATE OF DEATH Month <b>11</b> Day <b>29</b> Year <b>1961</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6.19.1892</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		10. AGE (In years last birthday) <b>69</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tax Collector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tax Collector</b>	
11. BIRTHPLACE (State or foreign country) <b>Hancock Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H Shives</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Andrews</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216.14.5992</b>	
17. INFORMANT <b>Mrs Maude L Shives Hancock Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>arteriosclerotic Heart Disease</b> (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) <b>arteriosclerotic Heart Disease</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12.2.61</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Warfordsburg Presbyterian</b>		22d. LOCATION (City, town, or country) (State) <b>Fulton Penn</b>	
23. FUNERAL DIRECTOR <b>Howard J. Shives Hancock Md</b>		24a. REC'D BY REGISTRAR <b>DEC 4 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur A. ...</b>		DATE SIGNED <b>11/29/61</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13204

## CERTIFICATE OF DEATH

Reg. Dist. No. 13188

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burkittsville</u>	
c. LENGTH OF STAY IN 1b <u>5 years</u>		d. STREET ADDRESS <u>10X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Reeder Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>B.</u> Last <u>Slifer</u>		4. DATE OF DEATH Month <u>11</u> Day <u>4</u> Year <u>1961</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/3/1874</u>
9. AGE (In years lost birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Charles Slifer</u>	
14. MOTHER'S MAIDEN NAME <u>M. Anna Gans</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. H.B. White, Yardley, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u> <u>422</u> DUE TO <u>arteriosclerosis gm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>min.</u> <u>hr.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month _____ Day _____ Year <u>19</u> Hour _____ a. m. _____ p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Nov 1</u> , 19 <u>60</u> , to <u>Nov 4</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Nov 1</u> , 19 <u>61</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>119 E. Antietam</u> DATE SIGNED <u>11/5/61</u> ACTUAL SIGNATURE <u>Louis G. Craff</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>Louis G. Craff</u> Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>11/6/1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>	22d. LOCATION (City, town, or county) _____ (State) _____ <u>Burkittsville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Company, Middletown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 7 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

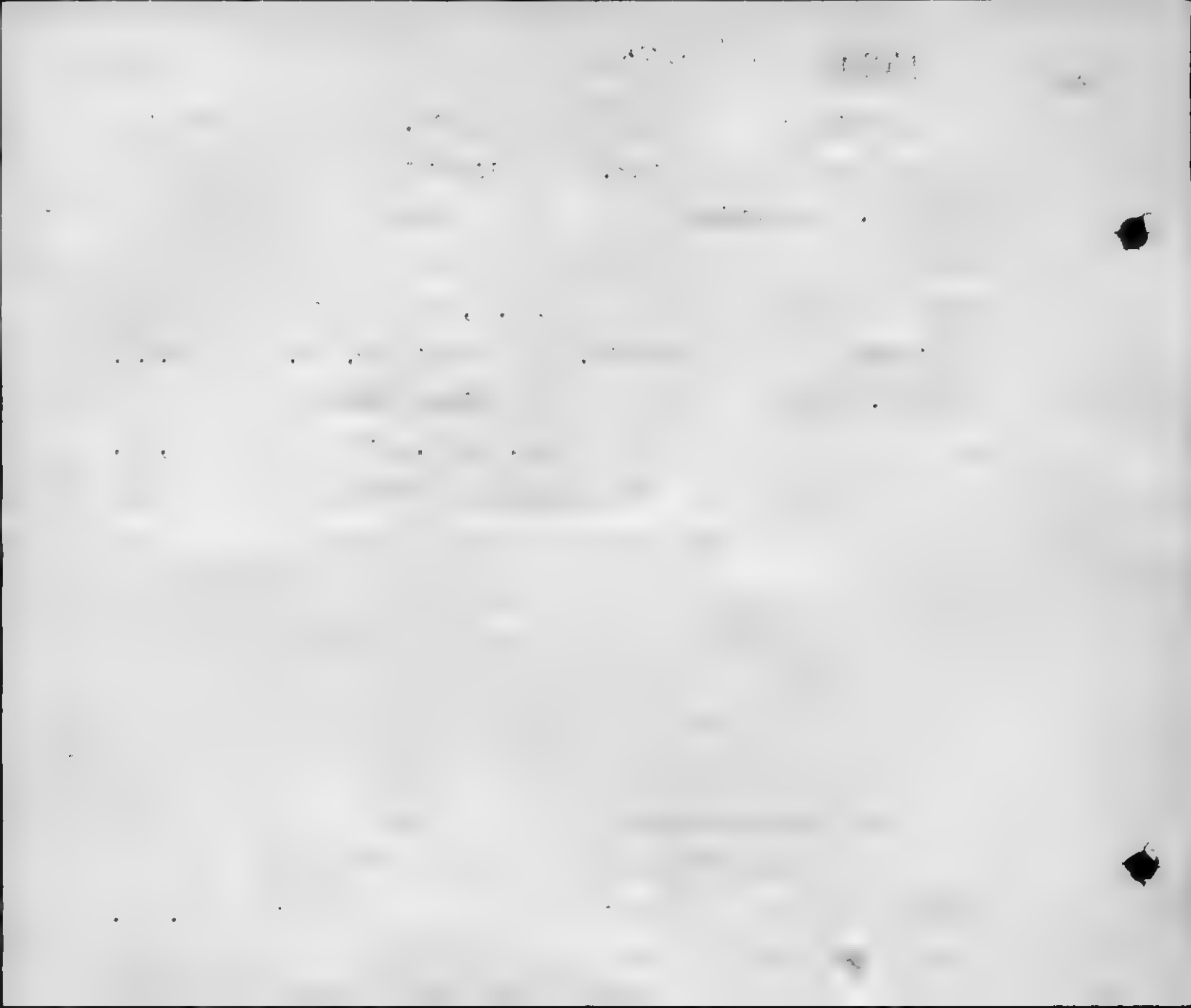
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13205

## CERTIFICATE OF DEATH

13189

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>2 mo.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Western Md. State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Highfield</b> d. STREET ADDRESS <b>Box 114</b>	
3. NAME OF DECEASED (Type or print) <b>CHARLES EDGAR SMITH</b>		4. DATE OF DEATH <b>NOV 15 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 8, 1885</b>
9. AGE (in years, est birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR <b>76</b> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rail Road</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Western Md.</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Frederick Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles W. Smith</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Warner</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Mrs. Alma L. Smith</b>	
17. INFORMANT <b>Highfield, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Pulmonary embolus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery disease</b> (c) <b>unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>(1) Paralysis Agitans</b> <b>(2) Hypertensive cardiovascular disease</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>9-13-61</b> , to <b>11-15-61</b> , that (I) (we) last saw the deceased alive on <b>11-15-1961</b> , and that death occurred at <b>11:48</b> PM, from the causes and on the date stated above.			
22a. SIGNATURE <b>Victor L. Ramos, M.D.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>VICTOR L. RAMOS, M.D.</b>		22d. ADDRESS <b>1500 PA AVE HAGERSTOWN MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/18/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Bethel</b>		23d. LOCATION (City, town or county) (State) <b>Washington Co., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Z. Grove</b>		25a. REC'D BY REGISTRAR <b>NOV 20 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles E. Kline</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

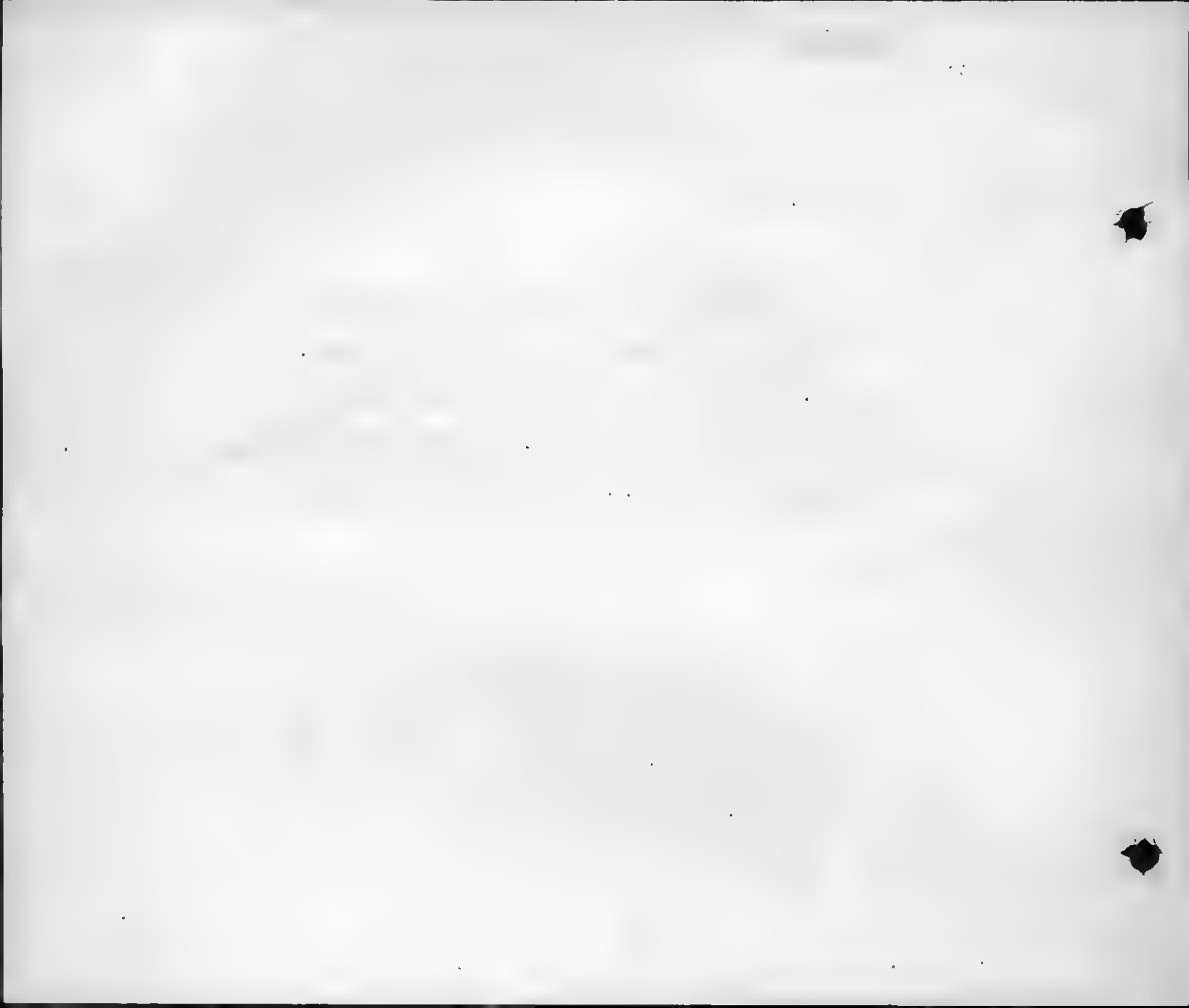
VR A15 (4)  
15M 9/59

13206

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13190

1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>35 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		d. STREET ADDRESS <b>1841 Maryland Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Goldie</b> Middle <b>Elizabeth</b> Last <b>Smith</b>		4. DATE OF DEATH Month <b>November</b> Day <b>5</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>August 13, 1898</b>
9. AGE (In years lost birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>10</b> Hours <b>10</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Cito Penn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George W. Mayhugh</b>		14. MOTHER'S MAIDEN NAME <b>Anna Carbaugh</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Mrs. Patsy Amsley</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>?</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>? 10 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 1957</b> to <b>Nov 5, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov 5, 1961</b> , and that death occurred at <b>11:20 P.M.</b> on the causes and on the date stated above.			
22a. SIGNATURE <b>Robert Vh Campbell</b> M.D.		22b. DATE SIGNED <b>11/7/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert Vh. Campbell</b>		22d. ADDRESS <b>Hagerstown Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-8-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Brethern Church Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Welsh Run, Penn.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		25a. REC'D BY REGISTRAR <b>DATE NOV 9 '61</b>	
ADDRESS <b>Hagerstown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	



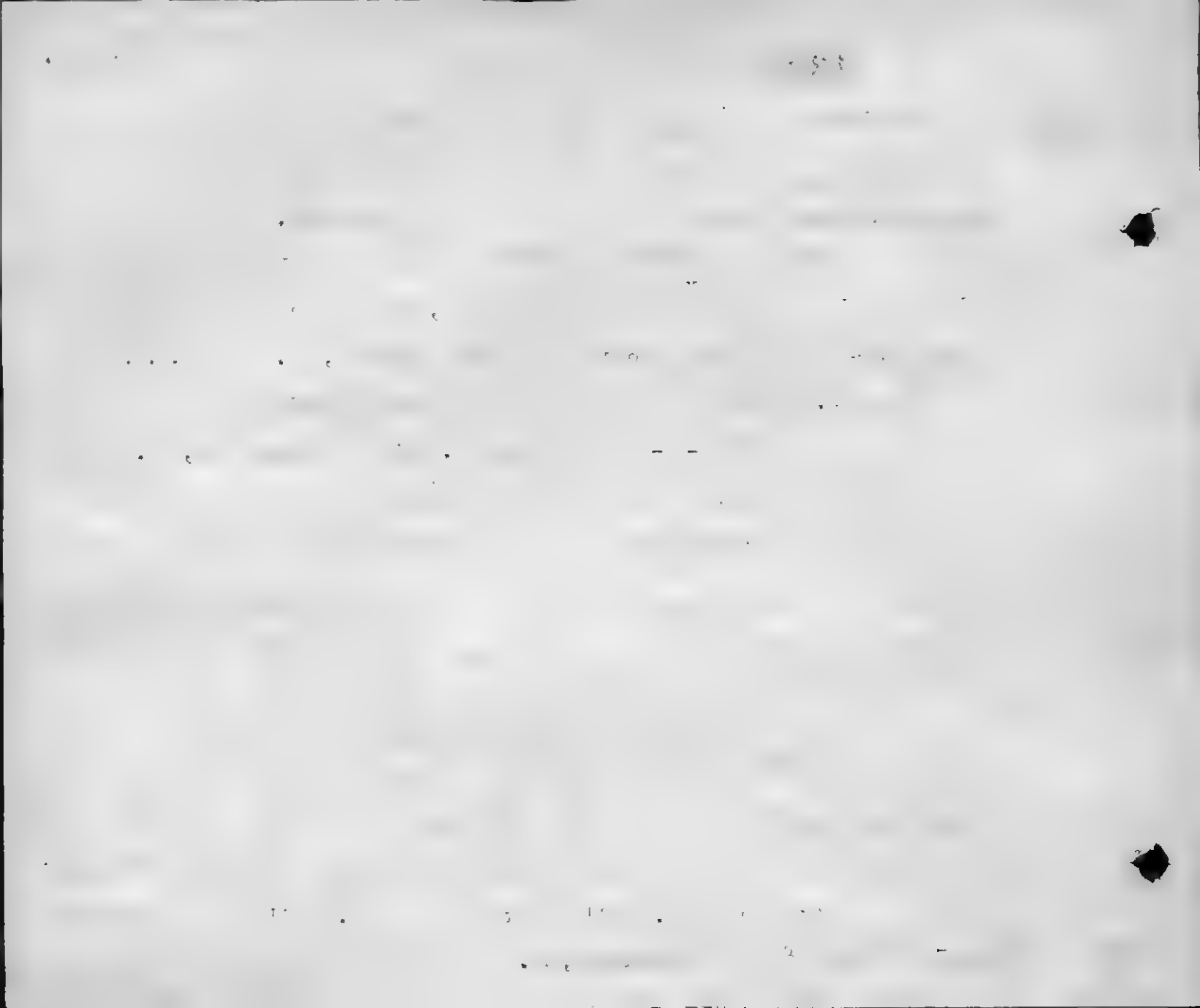
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13207 CERTIFICATE OF DEATH 13191											
1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN TB <b>most of life</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if instit on: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>1422 Potomac Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>JESSIE LORENA SMITH</b>						4. DATE OF DEATH <b>November 25 1961</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 1, 1900</b>		9. AGE (In years last birthday) <b>61 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Deputy Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Circuit Court</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Wilson District, Md.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>George S. Fockler</b>						14. MOTHER'S MAIDEN NAME <b>Laura Kate Mitchell</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>220-18-0025</b>		17. INFORMANT <b>George H. Smith</b>				Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> <b>443X</b> DUE TO (b) <b>Hypertensive Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b> <b>2 yrs.</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED <b>White</b> <input type="checkbox"/> <b>Not White</b> <input type="checkbox"/> <b>at work</b> <input type="checkbox"/> <b>not at work</b> <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from <b>NOV 25, 1961</b> , to <b>NOV 25, 1961</b> , that (I) (we) last saw the deceased alive on <b>NOV 25, 1961</b> , and that death occurred at <b>3A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Lloyd A. Hoffman</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/27/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Lloyd A. Hoffman</b>						22d. ADDRESS <b>214A Potomac St - Hagerstown, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/28/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>St. Paul's - Hagerstown Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Henson</b>						ADDRESS <b>Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 29 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Charles S. Hines</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

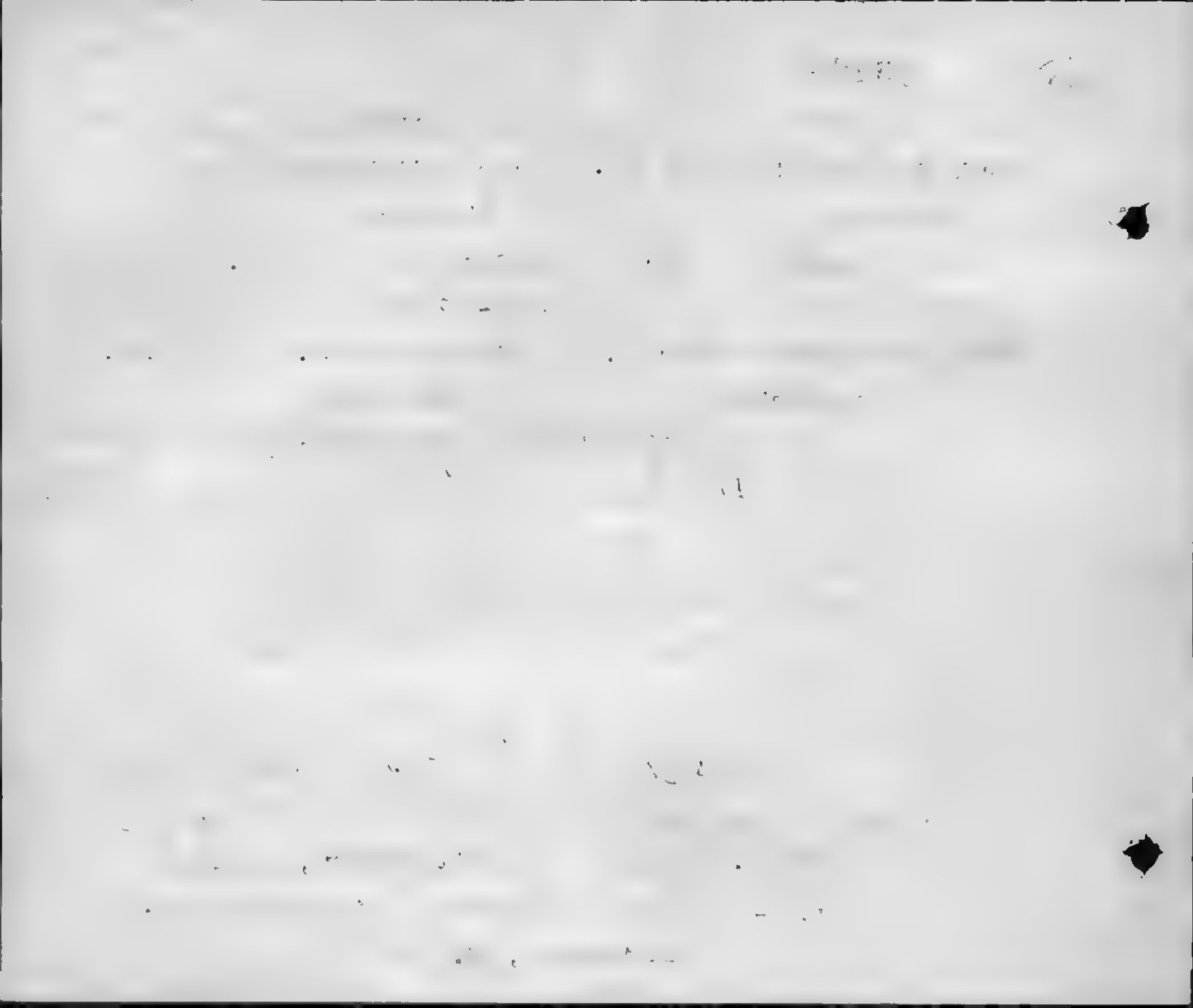
13208

13192

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Williamsport RFD #2</u> c. LENGTH OF STAY in lb <u>20 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pinesburg</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Williamsport RFD #2</u> d. STREET ADDRESS <u>Pinesburg</u>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>Bertha Mary Staley</u>		<b>4. DATE OF DEATH</b> Month <u>Nov.</u> Day <u>5</u> Year <u>19 61</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>July 17 1888</u>					
<b>9. AGE</b> (In years last birthday) <u>73</u> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months <u>3</u> Days <u>18</u></td> <td>Hours <u></u> Min. <u></u></td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months <u>3</u> Days <u>18</u>	Hours <u></u> Min. <u></u>	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Maker Rubber Heels Rubber Co.</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Williamsport Md.</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.								
Months <u>3</u> Days <u>18</u>	Hours <u></u> Min. <u></u>								
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>		<b>13. FATHER'S NAME</b> <u>John Chrisman</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Sarah Rowe</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>220 18 3107</u>		<b>17. INFORMANT</b> <u>Doris Hareford Pinesburg Williamsport Md RFD #2</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac. myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>IMMEDIATE</u> (a), stating the underlying cause last. (c) <u></u> DUE TO PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>									
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>11/5/61</u>					
<b>20f. (City or town)</b> <u>Williamsport, Maryland</u>		<b>20g. (County)</b> <u>Washington</u>		<b>20h. (State)</b> <u>Md.</u>					
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>11/5/61</u> <b>to</b> <u>11/5/61</u> <b>that (I) (we) last saw the deceased alive on</b> <u>11/5/61</u> <b>and that death occurred at</b> <u>6:30 PM</u> <b>from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <u>Ralph E. Young</u>		<b>22b. DATE SIGNED</b> <u>11/6/61</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Ralph E. Young</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Nov. 7-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Greenlawn Cemetery</u>					
<b>23d. LOCATION</b> (City, town or county) <u>Williamsport Md.</u>		<b>23e. REC'D BY REGISTRAR</b> <u>NOV 8 '61</u>		<b>23f. REGISTRAR'S SIGNATURE</b> <u>Arthur S. House</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Albert L. Leaf</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 10/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

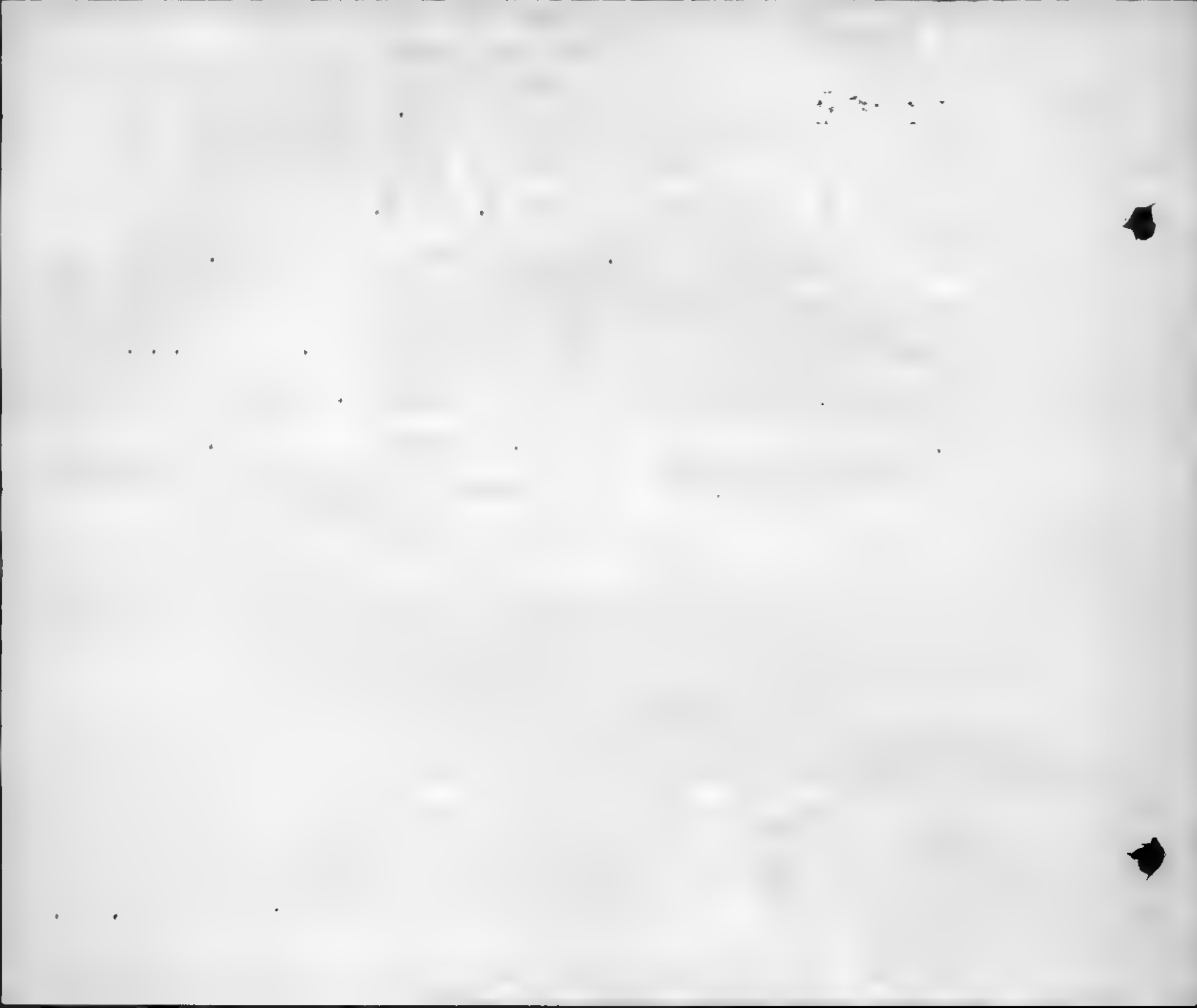
## 13209

### CERTIFICATE OF DEATH

Reg. Dist. No. **13193**

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <b>Pa.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Smithsburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		d. STREET ADDRESS <b>37 N. Main St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Martha</b> Middle <b>B.</b> Last <b>Stouffer</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>3,</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/20/1882</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Waynesboro, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Freeland W. Anderson</b>		14. MOTHER'S MAIDEN NAME <b>Margaret K. Snodderly</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO <b>No.</b>	
17. INFORMANT <b>Mrs. Wolfinger, Smithsburg Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Death Myocardial Infarction</b> DUE TO <b>arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>many years</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>November 2, 1961</b> , to <b>November 3, 1961</b> , that I last saw the deceased alive on <b>November 3, 1961</b> , and that death occurred at <b>10:15 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edson B Moody</b> M.D.		ADDRESS (Street, city or town, state) <b>145 So Prospect St Hagerstown Md.</b>	
PHYSICIAN'S NAME (Type) <b>Edson B Moody</b>		DATE SIGNED	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/5/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Green Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Waynesboro, Franklin Co., Pa.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter J. Shave, Waynesboro Pa.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>NOV 6 '61</b>		24b. REGISTRAR'S SIGNATURE <b>John J. Haver</b>	

MEDICAL CERTIFICATION



may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13194

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>5 1/2 years</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Northern Ave.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>Northern Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Loenholm</b> Last <b>Strong</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>18,</b> Year <b>19 61</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 29, 1910</b>
9. AGE (In years last birthday) <b>51</b> yrs		10. IF UNDER 1 YEAR Months <b>51</b> Days <b>18</b> Hours <b>19</b> Min <b>61</b>	11. IF UNDER 24 HRS Months <b>51</b> Days <b>18</b> Hours <b>19</b> Min <b>61</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>civil engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>construction wokr. Tokyo, Japan</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George V. Strong</b>		14. MOTHER'S MAIDEN NAME <b>Gerda Loenholm</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>579-05-6057</b>	
17. INFORMANT <b>Mrs. Mary Strong, Hagerstown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.10</b> DUE TO <b>Myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>arteriosclerotic heart disease</b> (c) <b>years.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Neurodermatitis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>18 JAN. 19 59</b> to <b>18 Nov. 19 61</b> , that (I) (we) last saw the deceased alive on <b>18 Nov. 19 61</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Richard T. Binford</b> M. D.		22b. DATE SIGNED <b>20 Nov. 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>RICHARD T. BINFORD, M. D.</b>		22d. ADDRESS <b>1135 POTOMAC AVENUE, HAGERSTOWN, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>11-22-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Ft. Myer, Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 22 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

101  
102

Properly  
Criminal

Unwarranted

Unwarranted

13211

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

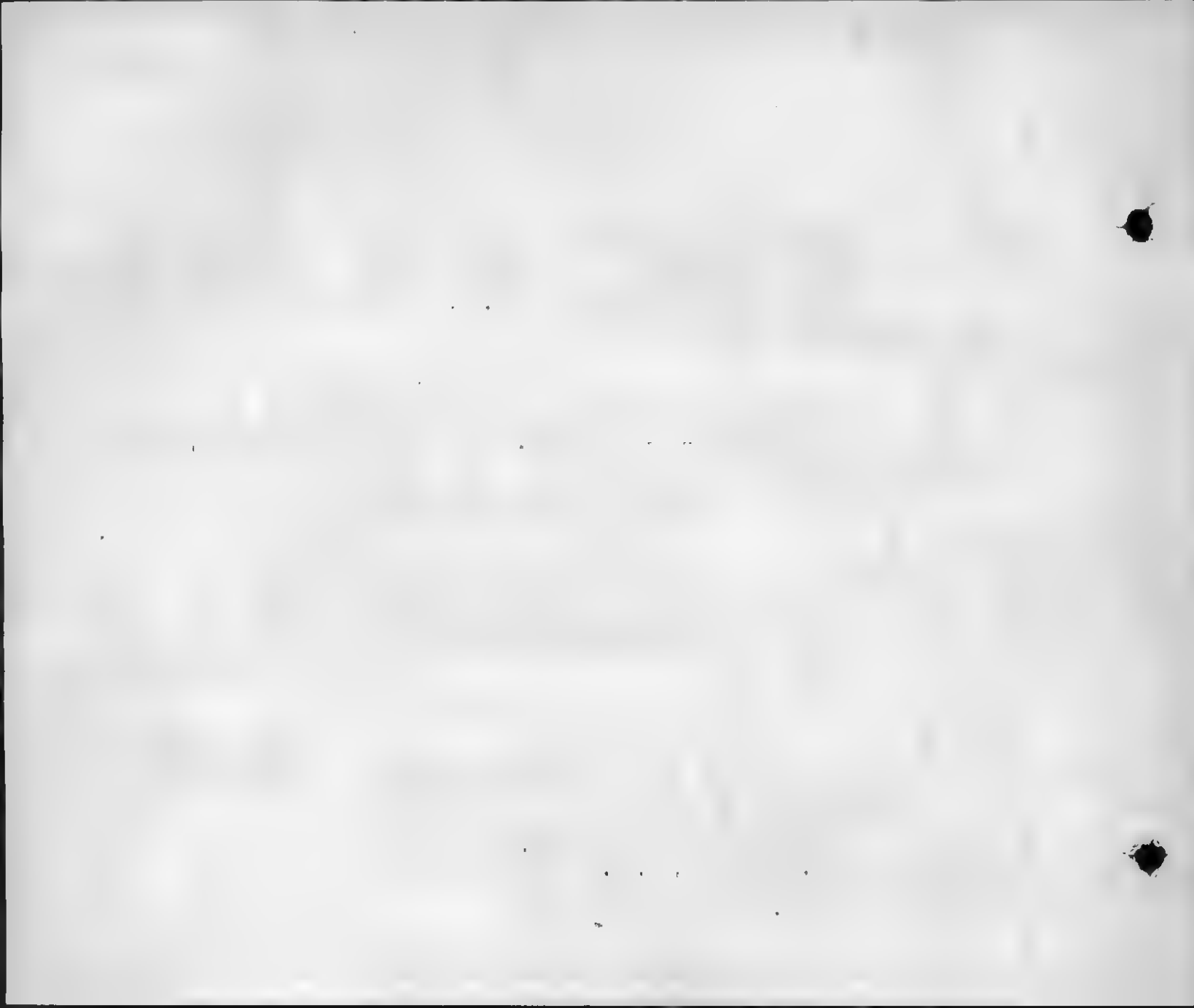
13195

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>20 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> <u>03</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>22 North Potomac Street</u>				d. STREET ADDRESS <u>22 North Potomac Street</u> <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Guy Thornton Stultz</u>				4. DATE OF DEATH Month Day Year <u>November 7 19 61</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 8, 1895</u>		9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Stultz</u>				14. MOTHER'S MAIDEN NAME <u>Nennie Anders</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>World War I 217-18-7213</u>		17. INFORMANT <u>Mrs. Clara Beans</u>		Address <u>Frederick, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion of circumflex and</u> DUE TO <u>right coronary vessels</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Advanced atherosclerosis severe</u> DUE TO (c) <u>10 years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Immed.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive cardiovascular disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Edward W. Ditto III</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Edward W. Ditto III, M. D.</u>				Act. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/11/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rocky Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Rural Woodsbore MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. C. Barton</u>				ADDRESS <u>Walkersville</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 10 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>L. S. Frank</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

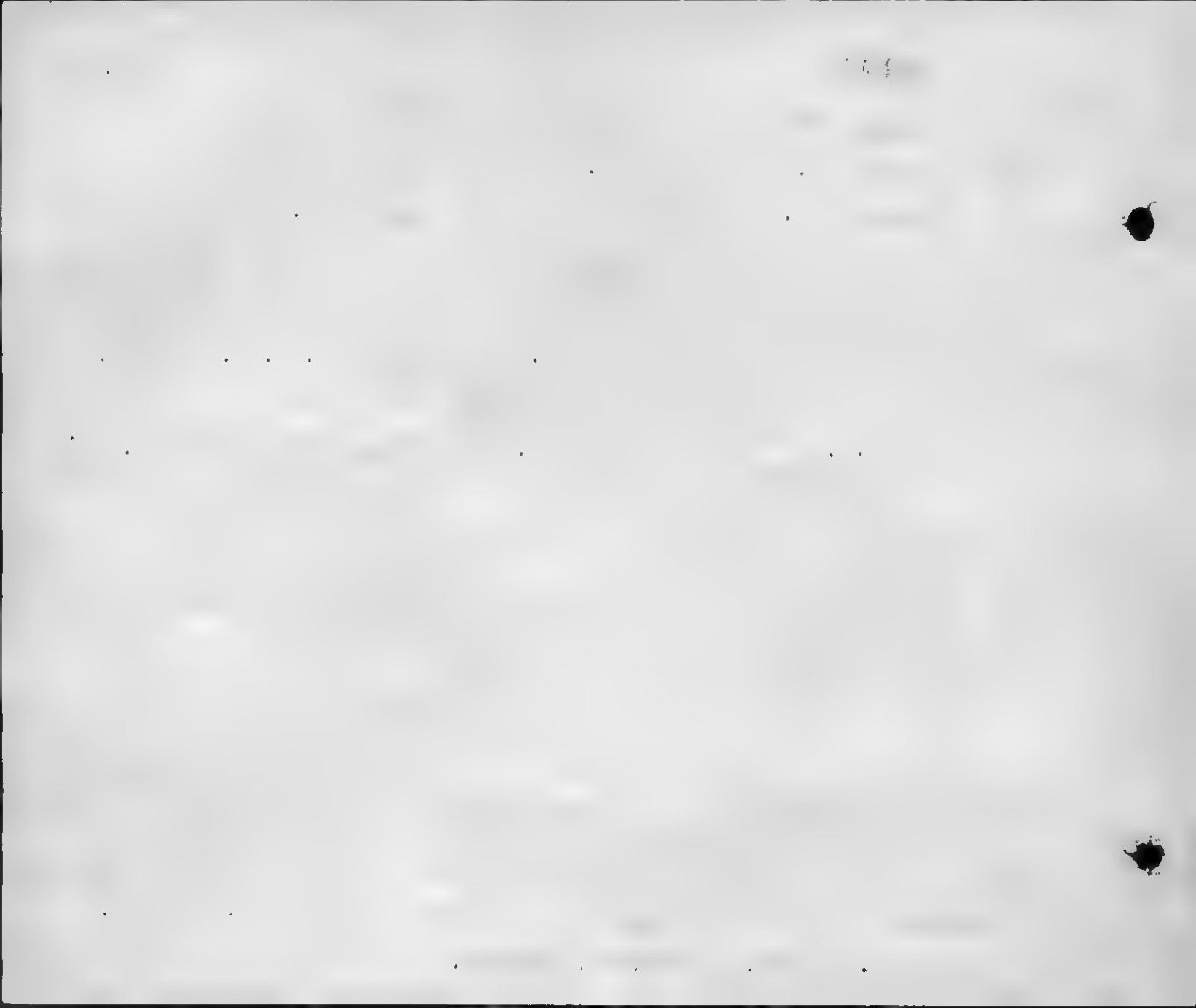
13212

13196

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Rt. #2</b> c. LENGTH OF STAY IN 1b <b>4 Mos.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Gateway Conv. Home</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b> d. STREET ADDRESS <b>1497 Salem Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>ALBERT LEWIS TROUPE</b>				<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>29</b> Year <b>19 61</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>October 11, 1889</b> <b>73</b> yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Yardman</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Jamison Door Co., Funkstown, Wash. Co. Md.</b>		<b>9. AGE</b> (In years last birthday) <b>73</b> yrs.		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>USA.</b>	
<b>13. FATHER'S NAME</b> <b>Scott Troup e</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Ella (No Record)</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> <b>W.W.#1</b>				<b>16. SOCIAL SECURITY NO.</b> <b>217-09-9546</b> <b>Mrs. Lewis Penner, 1497 Salem Ave.</b>			
<b>17. CAUSE OF DEATH</b> (Enter only one cause per line for (a) and (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chr. Cardiac Disease</b> <b>434.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>434.4</b> DUE TO (c) <b>Prostatic Hypertrophy</b>						<b>19. INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Prostatic Hypertrophy</b>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Sept 1, 1961</b> <b>to</b> <b>Nov 29, 1961</b> <b>that (I) (we) last saw the deceased alive on</b> <b>Nov 28, 1961</b> <b>and that death occurred at</b> <b>12:11</b> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>David R. Brewer</b> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>11/30/61</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>David R. Brewer</b>				<b>22d. ADDRESS</b> <b>Clear Spring Md.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>12/1/61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Rose Hill Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Hagerstown, Maryland.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Andrew K. Coffman, Hagerstown, Maryland.</b>				<b>25a. REC'D BY REGISTRAR</b> <b>DEC 4 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

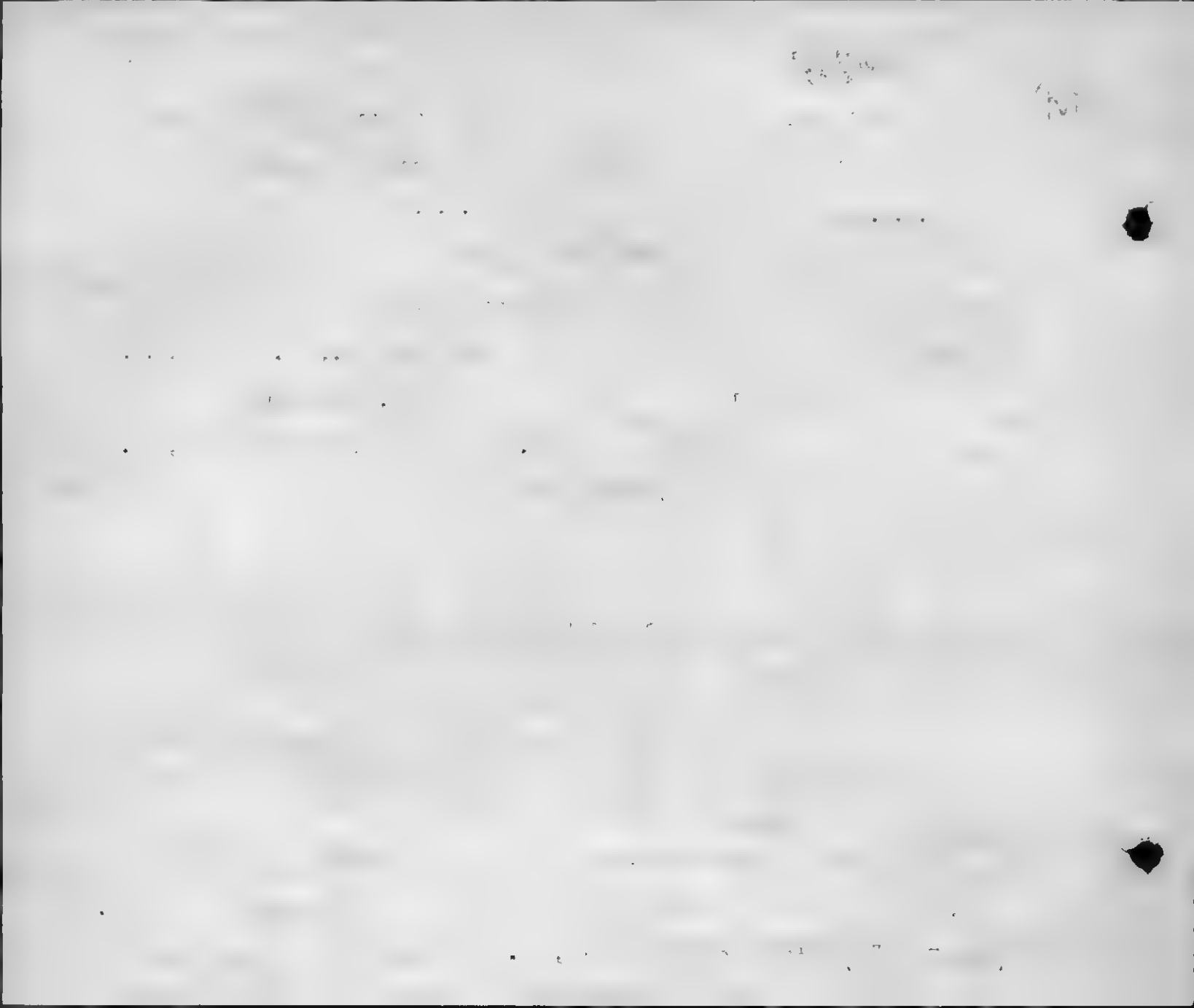
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13213

## CERTIFICATE OF DEATH

13197

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Clearspring</u> c. LENGTH OF STAY IN 1b <u>11 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R.F.D. # 1</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Clearspring</u> d. STREET ADDRESS <u>R.F.D. # 1</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>GERTRUDE</u> <u>ELIZABETH</u> <u>VANCE</u>		<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>12</u> Year <u>1961</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>October 13, 1869</u>
<b>9. AGE</b> (In years last birthday) <u>92</u> yrs.		<b>10. AGE</b> (In years last birthday) <u>92</u> yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Washington Co., Md.</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>U.S.A.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Lewis Schnebly</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary C. Middlekauff</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>	
<b>17. INFORMANT</b> <u>Mrs. Catherine Roney Clearspring, Md.</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHO PNEUMONIA</u> DUE TO <u>491X</u> Conditions, if any, which gave rise to immediate cause (b) <u>491X</u> (a), stating the underlying cause last. <u>491X</u> DUE TO <u>491X</u> (c) <u>491X</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20. INTERVAL BETWEEN ONSET AND DEATH</b> <u>6 DAYS</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE</u>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> e.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>NOV 8</u> <u>1961</u> , to <u>NOV. 12</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>NOV 11</u> <u>1961</u> , and that death occurred at <u>11:35 AM</u> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>Archie Robert Cohen</u> M.D.		<b>22b. DATE SIGNED</b> <u>11-13-61</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>ARCHIE ROBERT COHEN, M.D.</u>		<b>22d. ADDRESS</b> <u>CLEAR SPRING, MARYLAND</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>11/14/1961</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rose Hill Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Hagerstown Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Suter - Rouzer Funeral Home</u>		<b>25a. REC'D BY REGISTRAR</b> <u>NOV 16 '61</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>		<b>25c. REGISTRAR'S SIGNATURE</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VR A15 (4)  
15M 9/60

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**13214**  
**CERTIFICATE OF DEATH**  
**13198**

1. PLACE OF DEATH  
a. COUNTY Washington  
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Hagerstown  
c. LENGTH OF STAY IN b. 6mo.5 days  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Maryland State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE Maryland  
b. COUNTY Washington  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro (Rural)  
d. STREET ADDRESS Boonsboro RFD #1

3. NAME OF DECEASED (Type or print) CLEVELAND GROVER WALKER

4. DATE OF DEATH NOV 2 1961

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ B. DATE OF BIRTH Nov. 13 1884 9. AGE (In years last birthday) 76 yrs. IF UNDER 1 YEAR Months 11 Days 19 IF UNDER 24 HRS. Hours  Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Skeiner 10b. KIND OF BUSINESS OR INDUSTRY Silk Mill 11. BIRTHPLACE (County & State or foreign country) Falling Waters W. Va. U.S.A 12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME Daniel Walker 14. MOTHER'S MAIDEN NAME Annie Walters

15. WAS DECEASED EVER IN U.S. ARMED FORCES? No 16. SOCIAL SECURITY NO. 234 22 6820 17. INFORMANT Mr. Samuel Walker 628 Antietam Drive Hagerstown Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Uremia  
DUE TO (b) Carcinoma of the prostate with vesical neck obstruction  
DUE TO (c) Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While ☐ Not While ☐ at work ☐ at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 4-27-1961 to 11-2-1961, that (I) (~~was~~) last saw the deceased alive on 11-2-1961, and that death occurred at 539 M, from the causes and on the date stated above.

22a. SIGNATURE Young E. Chun M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ 22b. DATE SIGNED 11-2-1961

22c. PHYSICIAN'S NAME (Type) YOUNG E. CHUN 22d. ADDRESS 1500 Penna Ave Hagerstown Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Nov. 4-61 23c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery 23d. LOCATION (City, town or county) (State) Near Clearspring Md.

24. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leif ADDRESS Williamspoint, Md. 25a. REC'D BY REGISTRAR NOV 6 '61 25b. REGISTRAR'S SIGNATURE Orthur S. Thomas

21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

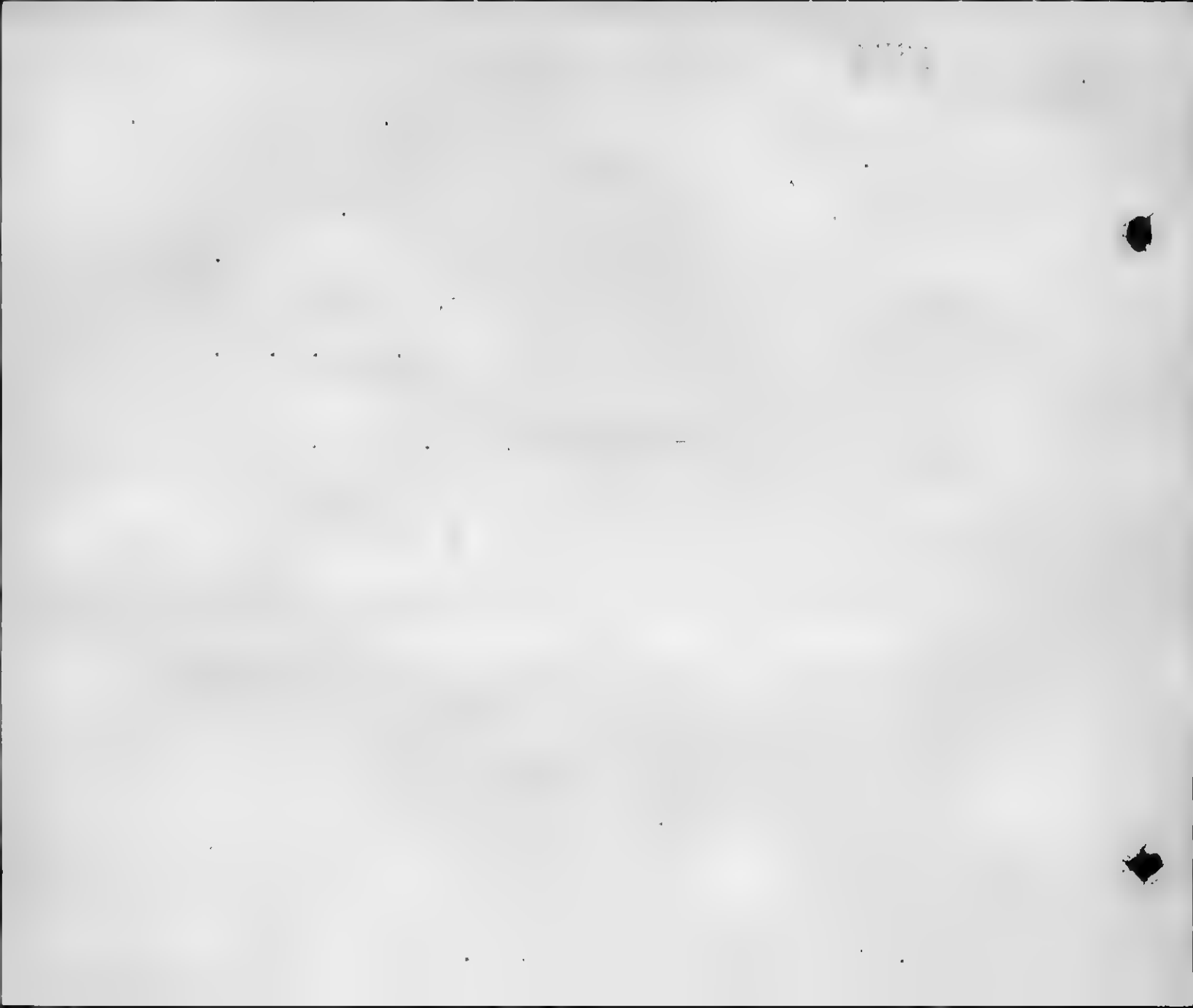
CERTIFICATE OF DEATH

Items 7 & 23 Film 4302 12/13/61 1wk

13199

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN IL <b>645 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>201 Ross St.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Md.</b> f. COUNTY <b>Wash.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>201 Ross St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Nora</b> Middle <b>Elsie</b> Last <b>Weaver</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>29,</b> Year <b>19 61</b>	
5. SEX <b>female</b> 6. COLOR OR RACE <b>white</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>July 30, 1882</b> 9. AGE (In years last birthday) <b>79</b> yrs. IF UNDER 1 YEAR: Months <b>7</b> Days <b>19</b> Hours <b>61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house work</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Edgemont, Wash. Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>David Shank</b>		14. MOTHER'S MAIDEN NAME <b>Clara Miller</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-34-0838</b>	
17. INFORMANT <b>Howard W. Weaver, Hagerstown, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCT</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Generalized Atherosclerosis</b> (c) <b>42.5</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>9</b> a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>11-26</b> , 19 <b>61</b> , to <b>11-29</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>11-26</b> , 19 <b>61</b> , and that death occurred at <b>7:20</b> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Harold R. Tritch</b> M.D.		22b. DATE SIGNED <b>11-30-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>HAROLD R. TRITCH JR MD</b>		22d. ADDRESS <b>301 N. Potomac St. Hagerstown</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>12/2/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Millers Church Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Leitersburg, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 6 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

MEDICAL CERTIFICATION



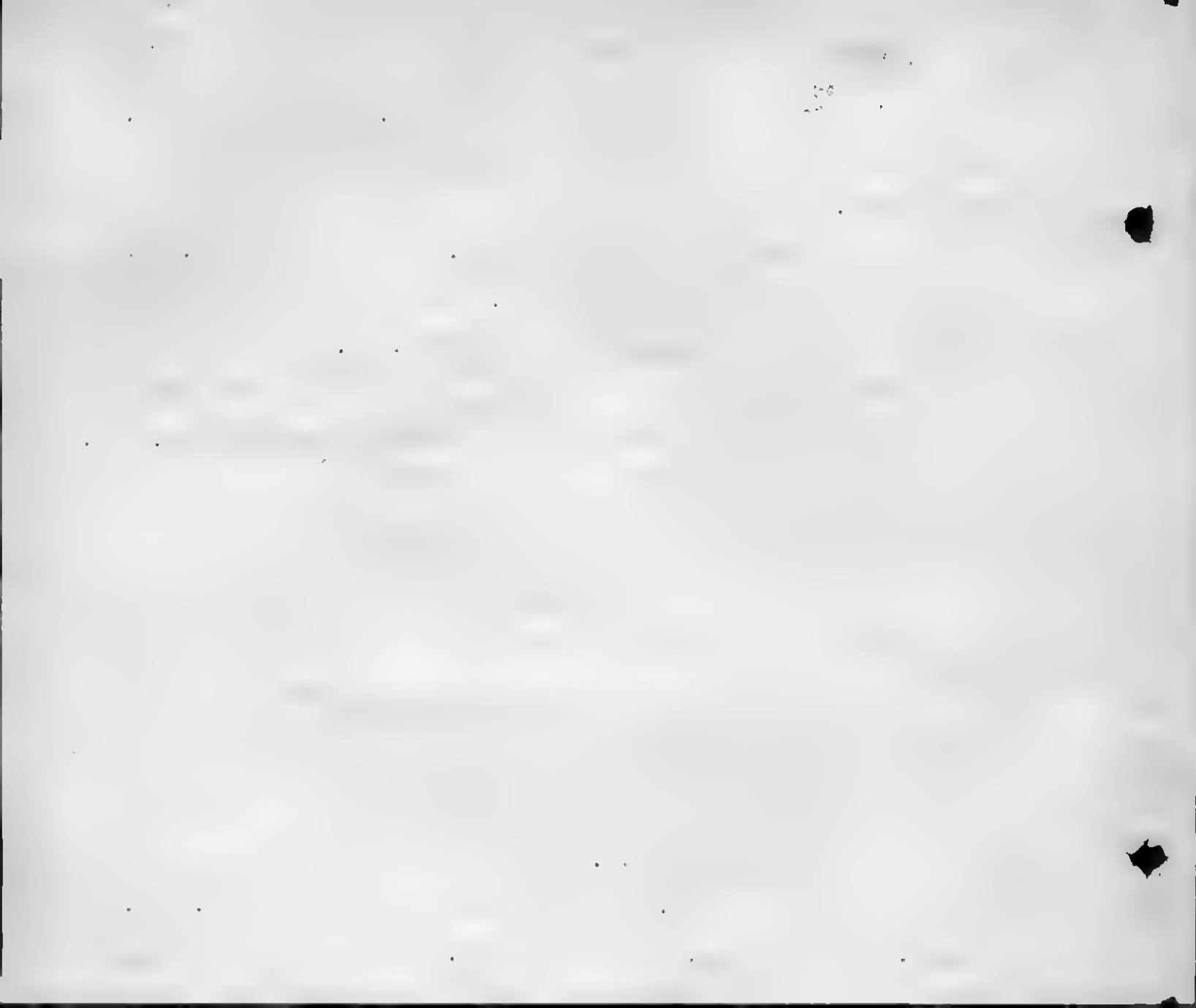
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 24 hours may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
13216 CERTIFICATE OF DEATH 13260															
1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN b <b>4 weeks</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Wilson Blvd.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Smithsburg</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>Samuel Franklin Webb.</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>30</b> Year <b>1961</b>											
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 10, 1881</b>		9. AGE (In years last birthday) <b>80</b>		10. UNDER 1 YEAR IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>labor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>farming</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Foxville, Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b></b>			
13. FATHER'S NAME <b>James Webb</b>				14. MOTHER'S MAIDEN NAME <b>Rose Anne Baker</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>213-12-7185</b>				17. INFORMANT <b>Mrs. Josephine Stevens, Hag., Md.</b>				Address <b></b>			
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b></b>										INTERVAL BETWEEN ONSET AND DEATH <b>30 Days</b> <b>10 Yrs.</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. a. <b></b>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) <b></b>		(County) <b></b>		(State) <b></b>			
21. I certify that (I) (this hospital) attended the deceased from <b>3-1-1961</b> to <b>11-30-1961</b> , that (I) (we) last saw the deceased alive on <b>11-1-1961</b> , and that death occurred at <b>2:45 A.M.</b> from the causes and on the date stated above.															
22a. SIGNATURE <b>Arthur L. Minnich</b>				M.D. <b></b>				ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11-30-1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>Arthur L. Minnich</b>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>				23b. DATE THEREOF <b>12-2-61</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Bethel Cemetery</b>				23d. LOCATION (City, town or county) <b>Frederick Co., Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>				ADDRESS <b>Smsithsburg, Md.</b>				25a. REC'D BY REGISTRAR <b>DEC 4 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Minnich</b>					



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13217

13201

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASH. COUNTY</u> c. LENGTH OF STAY IN It <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ZITTELSTOWN RURAL LIFE</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X ZITTELSTOWN MD. RURAL</u> d. STREET ADDRESS <u>1 BOONSBORO MD. R. 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>PATRICIA ANN WITEK</u>		4. DATE OF DEATH <u>NOVEMBER 29 1961</u>		5. SEX <u>FEMALE</u>	
6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPTEMBER 16 1901</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		9. AGE (in years last birthday) <u>60</u> yrs. <u>3</u> months <u>13</u> days	
11. BIRTHPLACE (County & State, or foreign country) <u>WASH. CO. HOSPITAL HAGERSTOWN MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>LESTER WITEK</u>	
14. MOTHER'S MAIDEN NAME <u>LOLA MONCAN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>LESTER WITEK BOONSBORO MD. R. 2</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASPHYXIA</u> 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>762.0</u> DUE TO (c) <u>762.0</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 1/2 hrs.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT.ON GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Medical exam was held post.</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Dept</u>	
20f. (City or town) <u>MD</u>		(County) <u>MD</u>		(State) <u>MD</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 27 1961</u> to <u>Nov 29 1961</u> that (I) (we) last saw the deceased alive on <u>Nov 27 1961</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Joseph Secondary</u>		22b. DATE SIGNED <u>DEC 6 '61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH SECONDARI</u>		22d. ADDRESS <u>BOONSBORO MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>DEC. 1, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>	
23d. LOCATION (City, town or county) <u>BOONSBORO WASH. CO. MD.</u>		23e. REC'D BY REGISTRAR <u>Arthur L. Kraus</u>		23f. REGISTRAR'S SIGNATURE <u>DEC 6 '61</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John N. Baat</u>		24a. ADDRESS <u>BOONSBORO MD.</u>			



13218

a. COUNTY

WASHINGTON

b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town)

HALF WAY RURAL 1 1/2 YEARS

3. NAME OF  
DECEASED  
(Type or print)

5. SEX

MALE

6. COLOR OR RACE

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

13. FATHER'S NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give war or dates of service)

No.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (e)

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS ALTOPSY

(a) 19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m.  
p.m. 19

20d. INJURY OCCURRED  
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from July, 13, 1961 to Nov. 20, 1961 that (I) (we) last saw the deceased alive on Nov. 20, 1961, and that death occurred at 7 p.m. from the causes and on the date stated above.

22. SIGNATURE \_\_\_\_\_

22c PHYSICIAN'S  
NAME (Type

J. D. Baxter, D.

23a. BURIAL, CREMATION,  
APPROVAL (Specify)

23b DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town or county)

(5) सिद्धांत

24 FUNERAL DIRECTOR'S SIGNATURE

ADDRESS  
BOONSBORO MD

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DATE DEC 6 '61 | *Arthur J. Kravitz*

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. It can please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
JAM 7/61

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13219

## CERTIFICATE OF DEATH

13203

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>109 E. FRANKLIN ST.</b>		d. STREET ADDRESS <b>109 E. FRANKLIN ST.</b>	
3. NAME OF DECEASED (Type or print) First <b>CLARA</b> Middle <b>VIRGINIA</b> Last <b>ZAHN</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>10</b> Year <b>1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/16/1883</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min. <b>78</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM A. NEWMAN</b>		14. MOTHER'S MAIDEN NAME <b>EMMA C. McGRUDER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MR. CHARLES W. ZAHN SR.</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4201</b> (b) <b>Arteriosclerotic heart disease</b> (c) <b>Hypertensive vascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b> <b>Indefinite</b> <b>Indefinite</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4:30p. 1961</b> , to <b>Nov. 10, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov. 9, 1961</b> , and that death occurred at <b>4:30p.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>B. B. Kneisley</b>		22b. DATE SIGNED <b>11/13/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M.D.</b>		22d. ADDRESS <b>148 West Washington Street Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11/13/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>		23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norman</b>		24b. ADDRESS <b>Hagerstown, Md.</b>	
25a. REC'D BY REGISTRAR <b>NOV 14 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>	

13218

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
132242											
132226											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>2500 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> f. COUNTY <b>Dorchester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rhodesdale</b> d. STREET ADDRESS <b>Box 44; RFD 1</b> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Marjorie Ella Haycraft</b>						4. DATE OF DEATH Month <b>November</b> Day <b>8</b> Year <b>19 61</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-18-1903</b>		9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months <b>09</b> Days <b>X</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Madelia, Minn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James B. Haycraft</b>						14. MOTHER'S MAIDEN NAME <b>Sarah Woodhall</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give year or dates of service) <b>None</b>						17. INFORMANT Address <b>May Haycraft, 92 Kenney Avenue Sharon Hill, Pa.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic pyelonephritis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>600.0</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatoid arthritis, multiple; diabetes mellitus</b>										INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>a.m.</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (If (this hospital) attended the deceased from <b>Jan. 1</b> , 19 <b>55</b> to <b>Nov. 8</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Nov. 8</b> , 19 <b>61</b> , and that death occurred at <b>3:15 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>L. V. Maldve</b>						M.D. <b>L. V. Maldve, M.D.</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11/9/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M.D.</b>						22d. ADDRESS <b>Deer's Head Hospital; Salisbury, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-13-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Phila. Memorial Park</b>		23d. LOCATION (City, town or county) <b>Frazer, Pa.</b>		23e. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.S. Marvel Co - Selmar, Del</b>						ADDRESS		25a. REC'D BY REGISTRAR <b>NOV 14 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Carlton E. Kraus</b>	

11551

34861

1M

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